

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02849

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County... Prince George's

City or town... (rural) Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs., 7 mos., 9 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 7 yrs., 7 mos., 9 days

## 3. (a) FULL NAME

EDUARDO B. ACLAO

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Filipino Single

6.(b) Name of husband or wife -

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years

October 14, 1893

8. AGE: Years Months Days If less than one day  
52 4 24 hrs. min.9. Birthplace Philippine Islands  
(Town, county, and state)

10. Usual occupation Laboratory Assistant

## 11. Industry or business

12. Name Pascual Aclao

13. Birthplace Philippine Islands

14. Maiden name ?

15. Birthplace Philippine Islands

16. Informant Decedent

## Address

17. Removal to Date thereof Mar. 10, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

## Cemetery or crematory

Location Bowie, Md.

18. Funeral director Martin E. Padavan  
Address Bowie, Md.19. Mar. 10, 1946 Rowland & Phillips  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Glenn Dale Sanatorium

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war -

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 10, 1946 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29, 1935, to Mar. 10, 1946  
and that I last saw him alive on Mar. 10, 1946

## Immediate cause of death

Pulmonary Tuberculosis

DURATION

25 yrs.

## Complication:

Right tuberculous empyema

1 yr.

## Due to:

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

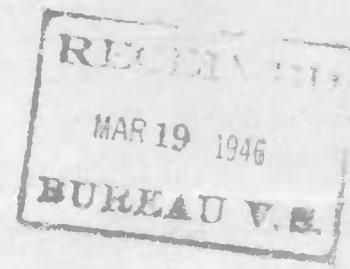
## Means of injury

Injured at work?

## 23. SIGNATURE

Daniel Leo Finegan MD,  
M. D. or other

Address Glenn Dale, Md. Date signed 3/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02850

Reg. Dist. No. 284

## 1. PLACE OF DEATH:

County

City or town *Clinton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Allen Mrs Bessie D.*

## 3. (b) Social Security Number

4. Sex

*F*

5. Color or race

*W*

6. (a) Single, married, widowed, or divorced

*Married.*

6. (b) Name of husband or wife

*Edgar Lee Allen*

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

*NOV. 7TH 1881*

8. AGE:

Years  
*64*

Months

Days

If less than one day

hrs. min.

9. Birthplace

*Pitts. Pa.*

(Town, county, and state)

10. Usual occupation

*Housewife*

11. Industry or business

*FRANK LEWIS*

MOTHER FATHER

12. Name

*MARGARET M. FRY*

13. Birthplace

*Pa.*

14. Maiden name

*MARGARET M. FRY*

15. Birthplace

*Pa.*

16. Informant

*Edgar L. Allen*

Address

*Clinton, Maryland*

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof *March 19-1946*  
(month) (day) (year)

Cemetery or crematory

*Cedar Hill Cemetery*

Location

*Sutherland, Maryland*

18. Funeral director

*Thomas J. Murray*

Address

*2007 - Nichols Ave SE Washington*

19. Date rec'd by registrar

*March 17 1946*

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MARYLAND*County *Clinton*City or town *Clinton*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 17 1946* at *3X*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec 20 1945 to March 17 1946*and that I last saw her alive on *March 16 1946*Immediate cause of death *Peritonitis**of intestinal obstruction**from constipation**due to*Due to *-*Other conditions *none at**mother*

(Include pregnancy within 3 months of death)

Major findings of operations *Same as above*Date of op. *Jan 10 1946*Autopsy results *no*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *no*

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

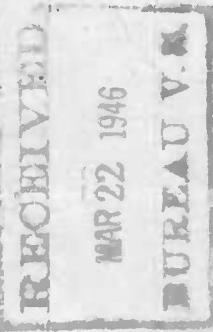
Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work? .....

23. SIGNATURE *Paul C. Clark M.D.*

M. D. or other

Address *Washington 14 DK*Date signed *May 17 1946*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

03122

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince George's  
 City or town..... (Rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 day

Hospital, Institution, or street address where death occurred:  
Glenn Dale Sanatorium

How long in hospital or institution?..... 1 day

## 3. (a) FULL NAME

Roy W. Ayers

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife..... —

7. Birth date of deceased (mo., day, yr.) ..... January 1, 1911

8. AGE: Years	Months	Days	If less than one day
35	2	29	..... hrs. ..... min.

9. Birthplace..... Oak Grove, W. Moreland Co., Virginia  
 (Town, county, and state)

10. Usual occupation..... Oil Truck Helper

11. Industry or business

12. Name..... William H. Ayers

13. Birthplace..... Caroline Co., Virginia

14. Maiden name..... Irene Marders

15. Birthplace..... King Geo. Co., Virginia

16. Informant..... Decedent

Address.....

17. Removal Date thereof..... Mar. 30/1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Washington, D.C.

Location..... 1 Wm Lee's Sons Co.

18. Funeral director.....

Address..... 300 4st. N.E. Wash. D.C.

19. Mar. 30, 1946 Rowland & Phillips  
 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)Street No..... 619 - 1st St. S. E. W.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

579-161-592

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 30, 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 MARCH 29, 1946, to MARCH 30, 1946

and that I last saw h. IM alive on MARCH 30, 1946

Immediate cause of death..... Pulmonary Tuberculosis  
 DURATION..... 2 yrs. 5 mos.

Due to.....

Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

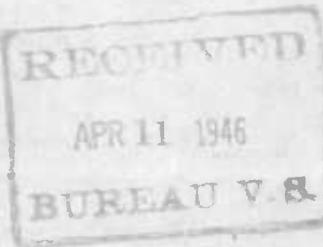
Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... Daniel Leo Finecane MD.  
 M. D. or other

Address..... Glenn Dale Md. Date signed..... 3/30/46



~~MARYLAND STATE DEPARTMENT OF HEALTH~~ Evidence for change of year of birth of deceased is shown on 2411 N. Charles St., Baltimore 460

02851

FILM NO. I O 1 APR 9 1946 *P. H. See Co.*

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: *Parkwood St.*  
 County *4103*.  
 City or town *Cottage City Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *6 months*  
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Mrs Anna H. W. BAKER*

4. Sex <i>Female</i>	5. Color or race <i>white</i>	6. (a) Single, married, widowed, or divorced <i>widowed</i>
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6. (b) Name of husband or wife <i>Edward E. Baker</i>
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7. Birth date of deceased (mo., day, yr.) <i>October 22, 1878</i>	6. (e) If alive, give age <i>years</i>
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8. AGE: Years <i>68</i>	Months	Days	If less than one day hrs. <i>.....</i> min. <i>.....</i>
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9. Birthplace <i>Germany</i>	(Town, county, and state)
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10. Usual occupation <i>Housewife</i>
---------------------------------------

11. Industry or business
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12. Name <i>Herman Riedel</i>
-------------------------------

13. Birthplace <i>Germany</i>
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14. Maiden name <i>Christie Vollmer</i>
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15. Birthplace <i>Germany</i>
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16. Informant <i>Catherine R. Clark</i>
---

Address <i>4103 - Parkwood St. Cottage City</i>
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17. Burial <i>Burial</i>	Date thereof <i>March 26 1946</i>
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(Burial, cremation, or removal. Which?)	(month) (day) (year)
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Cemetery or crematory <i>Fort Lincoln Cemetery</i>
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Location <i>3201 - Bladensburg Rd. Md.</i>
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18. Funeral director <i>Wm. J. Nalley</i>
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Address <i>3200 - R. J. Ave. Mt. Rainier Md.</i>
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19. March 26 1946 <i>James Seay</i>
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(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State <i>Maryland</i>	County <i>Prince Georges</i>
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City or town <i>Cottage City</i>	(If outside city or town limits, write RURAL and give nearest town)
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Street No. <i>4103 - Parkwood St.</i>	(If rural, give LOCATION)
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2. (a) If veteran, name war:

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Mar 24 1946 at 2:45 p.m.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Mar 41 to Mar 24 1946* and that I last saw her alive on *Mar 23 1946*Immediate cause of death *Carcinoma of colon with metastasis*Due to *metastasis*Duration *5 yrs*Other conditions *.....*

(Include pregnancy within 8 months of death)

Major findings of operations *Carcinoma of colon -*Date of op. *Mar 1941*Autopsy results *.....*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *.....* Date of *.....*Where did injury occur? *.....* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *.....*Means of injury *.....* Injured at work? *.....*23. SIGNATURE *Layrus Klerenling M.D.*M. D. or other *.....*Address *1339 - Mount Vernon St. N.E.*Date signed *3/24/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STORY TO TRUSTEES STATE CHARTER

RECEIVED MAR 28 1946

STORY TO STANFORD

HOLY NAME

RECEIVED

MAR 28 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

02852

243.

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Prince George's  
 City or town..... (rural) Glenn Dale Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 mo., 8 days

Hospital, Institution, or street address where death occurred:..... Glenn Dale Sanatorium

How long in hospital or institution?..... 1 mo., 8 days

## 3. (a) FULL NAME

BARNES, ROY E

## 4. Sex

Male	5. Color or race	6.(a) Single, married, widowed, or divorced
	Colored	Single

## 6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) ..... October 6, 1915

8. AGE: Years Months Days If less than one day

30	4	23	hrs.	min.
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9. Birthplace..... Tazwell, Virginia  
 (Town, county, and state)

10. Usual occupation..... General Work -

11. Industry or business..... Thompson's Dairy

12. Name..... Robert Barnes

13. Birthplace..... Tazwell, Virginia

14. Maiden name..... Margaret Spotts

15. Birthplace..... Tazwell, Virginia

16. Informant..... Decedent

Address

17. Removal to..... Washington, D.C. Date thereof..... Mar. 1 1946  
 (Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location..... Washington, D.C.

18. Funeral director..... H. Ernest Barnes Jr.

Address..... 1432 - Jan St. N.W.

19. Date rec'd by registrar..... Mar. 1 1946 Rowland S. Phillips  
 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1316 V. Street N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

719-05-2550

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

March 1, 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/21 1946 to 3/1 1946

and that I last saw him alive on April 1, 1946

Immediate cause of death..... pulmonary

Tuberculosis

DURATION  
3 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

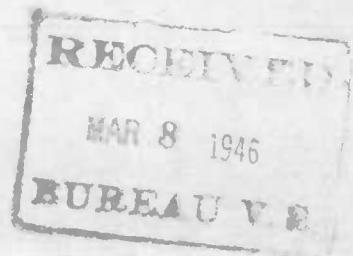
Means of injury

Injured at work?

23. SIGNATURE..... Daniel Leo Finegan M.D.

M. D. or other

Address..... Glenn Dale, Md. Date signed..... Mar. 1 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25

## CERTIFICATE OF DEATH

02853

231

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Prince George  
 City or town..... Bradbury Hgts. Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 SA  
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Lawrence Bowles  
 Male white Single

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.)

6. (c) If alive, give age..... years

May 31, 1939

8. AGE:

Years

Months

Days

If less than one day

. hrs. . min.

9. Birthplace.....

D.C.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name..... Jerome

13. Birthplace.....

Manassas, Va.

14. Maiden name.....

Dancy Belle Frye

15. Birthplace.....

Lucketts, Va.

16. Informant.....

Address

Bradbury Hgts. Md.

17. Burial, cremation, or removal?.....

Date thereof..... (month) (day) (year)  
 Removal

Cemetery or crematory.....

Location.....

Washington DC

18. Funeral director.....

Address

60 W. Chambers. Co.

19. Date rec'd by registrar.....

19. (Date signed.....)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Prince George

City or town..... Bradbury Hgts.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3-14 1946 at 5:57 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 1946, to March 14, 1946

and that I last saw him alive on March 14, 1946.

Immediate cause of death.....

Toxic myocarditis  
or congestive failure

Due to.....

Due to.....

Other conditions..... Measles 7 days

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

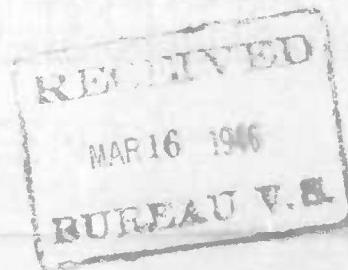
Means of injury.....

Injured at work? .....

23. SIGNATURE..... William Brannin

M.D. C.R.

Address..... Capitol Hgts., Md. Date signed..... 3/14/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

02857

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County..... Prince George  
 City or town..... Cheverly  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 26 days.

Hospital, institution, or street address where death occurred:

Prince George General Hospital

How long in hospital or institution?..... 26 days.

## 3. (a) FULL NAME

Robert Caruthers

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Lydia Caruthers

7. Birth date of deceased (mo., day, yr.)

December 12 1868

6.(c) If alive, give age..... years

8. AGE:

Years  
77Months  
3Days  
14

If less than one day

hrs. .... min.

9. Birthplace.....

(Town, county, and state)

W.C.B.

10. Usual occupation

Clerk.

11. Industry or business

Maurice Caruthers

12. Name..... Maurice Caruthers

W. Va.

13. Birthplace.....

14. Maiden name..... Emily Lanham

W. Va.

15. Birthplace.....

16. Informant..... Mrs. Lydia Caruthers

Address 4910 Lucyensbury Rd - Rivendale, Md.

17. Burial

Date thereof..... March 18, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Et Lincoln

Location..... Colmar Manor Md

18. Funeral director..... J. Gosch's Sons

Address..... Hyattsville Md

19. 3/16 1946 Ananda Dauney  
 (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George

City or town..... Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 4910 Lucyensbury Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 14 1946 at 12:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 1946 to March 14 1946

and that I last saw him alive on March 14 1946

Immediate cause of death.....

cerebral hemorrhage

Due to..... cerebral embolism

Due to..... coronary thrombosis

Other conditions..... arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... John M. Jones

M. D. or other

Address..... Prince George Hosp Date signed..... 17-46

RECEIVED

MAR 18 1946

BUREAU V.E.

02854

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County... Prince George's

City or town... (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 1 day

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 1 day

## 3. (a) FULL NAME

JETHRO CASON

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife Ola Mae Cason

7. Birth date of deceased (mo., day, yr.) December 26, 1913

8. AGE: Years	Months	Days	If less than one day
32	2	12	hrs. min.

9. Birthplace Philadelphia, Pennsylvania  
(Town, county, and state)

10. Usual occupation Truck Driver

## 11. Industry or business

MOTHER FATHER	12. Name	Robert Cason
	13. Birthplace	Georgia

MOTHER	14. Maiden name	Rose Outlaw
	15. Birthplace	Georgia

16. Informant Decedent

Address Removal to

17. (Burial, cremation, or removal. Which?) Date thereof May 13, 1946  
(month) (day) (year)

Cemetery or crematory Washington D.C.

Location Washington &amp; Schuyler Inc.

18. Funeral director Address 224 - R St N.W.

19. Mar. 10, 1946 Rowlands Phillips  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C.

County Washington

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 2450 Nichols Ave. S.E.

(If rural, give LOCATION) ✓

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1946, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 9, 1946, to Mar. 10, 1946, and that I last saw him alive on March 10, 1946.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

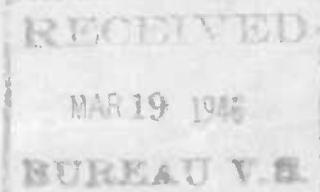
Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Panicase M.D.  
Glenn Dale, Maryland Date signed 3/10/46

M. D. or other



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02855

243

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Prince George's  
 City or town... (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 2 mos., 4 days.

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?... 2 mos., 4 mos.

## 3. (a) FULL NAME

CHESTER, MAY EVELYN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 16, 1924

8. AGE: Years	Months	Days	If less than one day
21	5	4	hrs. min.

9. Birthplace... Washington, D. C.  
(Town, county, and state)

10. Usual occupation... Waitress

## 11. Industry or business

Thomas E. Chester

12. Name.....

13. Birthplace ?

14. Maiden name... May E. Padgett

15. Birthplace Washington, D. C.

16. Informant... Decedent

Address

17. Burial... Removal Date thereof... Mar. 27, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Cedar Hill Cemetery

Location... Prince George's Co., Md.

18. Funeral director...

W.W. Chambers Co.

Address... 517. 11th St. S.E.

19. Mar. 20, 1946 Registered by Philip  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C. County.....

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No... 3223-6th St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war....

## 3. (b) Social Security Number

124-20-9773

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 20, 1946, at 11:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 16, 1946, to March 20, 1946,

and that I last saw h. e. alive on March 20, 1946.

Immediate cause of death...

Pulmonary  
Tuberculosis

DURATION

5 mos.

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

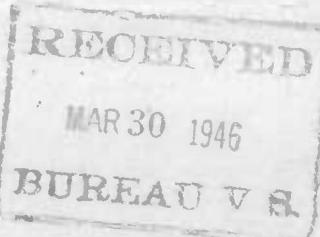
Means of Injury

Injured at work?

23. SIGNATURE... Daniel Leo Finegan M.D.

M. D. or other

Address... Glenn Dale, Md. Date signed... 3/20/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02856

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County... Prince George  
City or town... Allentown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 year

Hospital, Institution, or street address where death occurred:

7162 Allentown Rd

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah Louisa Clark

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) Aug 27, 1853

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
92 6 38 hrs. min.

9. Birthplace Massachusetts

(Town, county, and state)

10. Usual occupation house

## 11. Industry or business

12. Name... Mary K Powell

13. Birthplace... Boston

14. Maiden name... Mary K Powell

15. Birthplace... Boston

16. Informant... Mary K Powell

Address 7162 Allentown Road

17. Removal Date thereof... 3/6/46

(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Washington Hill

Location... W.W. Chambers Rd

18. Funeral director... W.W. Chambers Rd

Address 317-11 St. S.E.

19. 3/6 1946 Carr. Z. Campbell  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George

City or town... Allentown

(If outside city or town limits, write RURAL and give nearest town)

Street No... 7162 Allentown Rd

(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946 at 10<sup>50</sup>A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..., to 19...

and that I last saw h. alive on 19...

Immediate cause of death... Seminal pneumonia

DURATION

Due to... Toxemia

Due to... Fracture of left hip

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

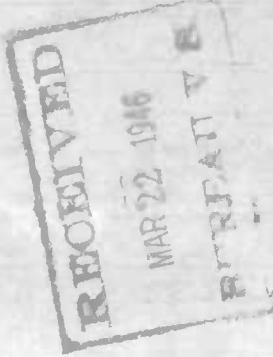
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. accident Date of 3-1-46Where did injury occur? Allentown (City or town) P.S. Hill (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fell in her room Injured at work NoKeeps pet medecine Games Boys23. SIGNATURE Carr. Z. Campbell M.D. or other Dr. J. C. CampbellAddress President Dr. J. C. Campbell Date signed 3-5-46



copy sent to Co. H.Q. 3/22/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

★ 02858245  
Reg. Dist. No. 1

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 days

Hospital, institution, or street address where death occurred:.....

Belair Memorial Hospital

How long in hospital or institution?.....

3 days

## 3. (a) FULL NAME

Mrs. Elizabeth Conklin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

B. (b) Name of husband or wife.....

Mr. William F. Conklin

7. Birth date of deceased (mo., day, yr.)

Sept. 26, 1889

B. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

56

5

20

hrs.

min.

9. Birthplace.....

Jersey City, N.J.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Own home

MOTHER FATHER

12. Name..... Charles M. Conklin

13. Birthplace.....

Edinburgh, Scotland

14. Maiden name..... Anna Little

15. Birthplace.....

Tyrone County, Ireland

16. Informant.....

Belair Memorial Hospital Records

Address.....

Rivendale, Md.

17. Burial.....

Buried

Date thereof..... 3/18/46  
(month) (day) (year)

Cemetery or crematory.....

1400 Chapin St. N.W.

Location.....

Brookline, N.W.

18. Funeral director.....

W.W. Chambers Co

Address.....

Rivendale, Md.

19. Date rec'd by registrar.....

March 18, 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

J.C.

County.....

City or town.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

1320 Park Lane N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

18 March 1946 at 8:20A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 March 1946 to 17 March 1946 and that I last saw her alive on 17 March 1946.

Immediate cause of death..... Bronchitis-pneumonia  
Cardiac failure DURATION 4 days

Due to.....

Due to.....

Other conditions..... Atrial fibrillation 7 days  
(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

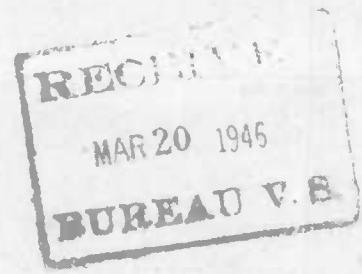
Injured at work?

23. SIGNATURE.....

Harold F. M. E. Carr

M. D. or other

Address..... 3100-20th St. N.E. Date signed..... 18 March 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02859

(60-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince George

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, Institution, or street address where death occurred:

1108 Linden Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

deceased (mo., day, yr.)

Feb 11, 1946

6.(c) if alive, give age years

8. AGE:

Years

Months

Days

less than one day

21 hrs. min.

9. Birthplace

Washington

DC (Town, county, and state)

10. Usual occupation

none

11. Industry or business

12. Name

Michael M. Coughlin

13. Birthplace

Blumberg, Sova

14. Maiden name

Betty Henlin

15. Birthplace

Washington DC

16. Informant

Michael M. Coughlin

Address

1108 Linden Ave., Takoma Park

17. Burial

Date thereof Mar 5 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mt Olivet Cemetery

Location

Washington D. C.

18. Funeral director

Albert &amp; Irsh

Address

641-H 4th &amp; Ward D.C.

19. Deceased

Date of death

March 4 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Prince George

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1108 Linden Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 4 1946 at 6:45 AM

19. to 19.

and that I last saw h. alive on

19. to 19.

Immediate cause of death

Sudden cerebral hemorrhage

DURATION

Due to Congenital vascular deformity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

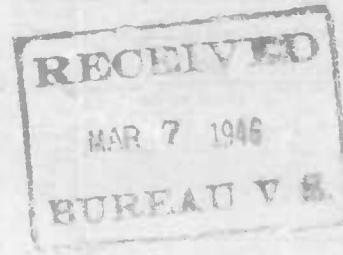
Means of injury Injured at work

Deputy medical Examiner

James J. Ford M. D. or other

Forestville Md Date signed 3-4-46

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02860

245

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

Prince George

City or town Rogers Height

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

5022 - 54th Place

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male White

5. Color or race

Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 11, 1878

6. (c) If alive, give age

years

8. AGE:

Years Months Days It less than one day  
67 hrs. min.

9. Birthplace

Washington DC

(Town, County, and state)

10. Usual occupation

Baker

11. Industry or business

Harris Baker Curtin

12. Name

Washington DC

13. Birthplace

Martha Elizabeth Williams

14. Maiden name

Washington DC

15. Birthplace

James E. Curtin

16. Informant

5022 - 54th Place Rogers Height

Address

Burial

Date thereof March 11, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory Cedar Hill

Location Suitland Md.

18. Funeral director

William J. Valley

Address

3200 - R. I. Ave. Mt. Rainier, Md.

March 10 1946 James Seery

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Prince George

City or town Rogers Height

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5022 - 54th Place

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946 at 1:30A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw him alive on

19.

Immediate cause of death

Acute Congestive heart failure

Due to Coronary occlusion

Due to Cardiovascular renal disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as stated

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

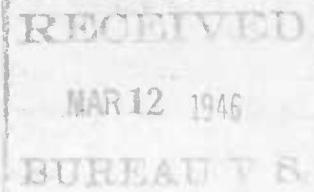
Means of injury

Injured at work? Deputy medical examiner

23. SIGNATURE

M. D. or other Forestville Md. Date signed 3-7-46

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02861

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County

PRINCE GEORGES

City or town

HYATTSVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 YRS.

Hospital, institution, or street address where death occurred:

5800 40TH AVE.

How long in hospital or institution?

## 3. (a) FULL NAME

DOROTHEA LOUISE DAVIS

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE WHITE DIVORCED.

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

NOV. 8 1914

8. AGE:

Years

Months

Days

If less than one day

31

hrs. min.

9. Birthplace

STATE LINE PENNA.

(Town, county, and state)

10. Usual occupation

HOUSEWIFE.

OWN HOME.

11. Industry or business

HARRY C. BURGER.

MOTHER FATHER

12. Name

STATE LINE PA.

13. Birthplace

EVA GRIFFIN.

14. Maiden name

JOHNSON CITY TENN.

15. Birthplace

16. Informant

HARRY C. BURGER.

Address

1341 FAIRMONT ST. N.W. WASH. D.C.

Burial

Date thereof Mar 30, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Washington D.C.

18. Funeral director

L. Gascha Sons

Address

Hyattsville Md.

19. Date rec'd by registrar

March 30

1946

James Seery

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD.

County

PR. GEO.

City or town

HYATTSVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No.

5800

40TH AVE.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 27 1946 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Asphyxiation

Due to Asphyxiation

Due to monoxide poison

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of 3-27-46

Where did injury occur? Hyattsville (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) 1. Home

Means of informed Jossing Inj. to Work

Respectfully Free Death Examiner

23. SIGNATURE

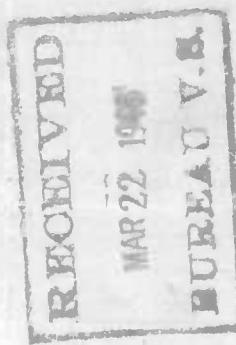
T. DeLoach Jr. M. D. or other

Address

Hyattsville Date signed 3-29-46







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 125-B

02863

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County..... Prince George  
 City or town..... Beverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George General Hospital  
 Prince George General Hospital

How long in hospital or institution?

2 days 17 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington D.C. County..... Prince George  
 City or town..... Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16333 Rollins Ave S.E.

(If rural, give LOCATION)

## 3. (a) FULL NAME

Lawrence J. Hart

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife..... Martha F. Burrows

7. Birth date of deceased (mo., day, yr.) July 25, 1894

8. (c) If alive, give age 51 years

8. AGE: Years Months Days If less than one day  
52 7 18 hrs. min.

9. Birthplace..... Patsot County, Virginia

(Town, county, and state)

10. Usual occupation..... Foreman - Washington Sand &amp; Gravel

## 11. Industry or business

12. Name..... Paul J. Hart

13. Birthplace..... Virginia

14. Maiden name..... Martha A. Bond

15. Birthplace..... Patrick County, Va.

16. Informant..... Mrs. Lawrence J. Hart

Address 6333 Rollins Ave S.E.

17. Remains..... Date thereof... Mar 7 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Washington National Cemetery

Location..... Suitland, Md.

18. Funeral director..... Deal Funeral Home

Address 4812 Laurel St. N.W. Wash. D.C.

19. 3/7 1946 Amanda Dauney

(Date rec'd by registrar)

2.(a) If veteran, name war...

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1946, at 1045 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 18, 1945, to March 7, 1946

and that I last saw him alive on March 7, 1946

Immediate cause of death..... Pulmonary

abscess (inflamed)

cause undetermined

Due to..... Abscess of liver

Inflammation of lungs

Due to.....

Other conditions..... Perforations of

ascending colon

(Include pregnancy within 3 months of death)

Major findings of operations..... Perforations of ascending

colon

Date of op. Mar 18, 1946

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

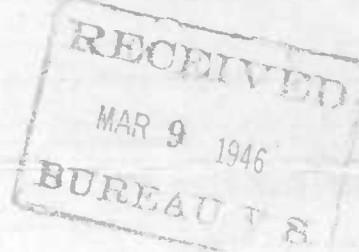
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... William Brannin M. D. or other

Address..... Capitol Heights, Md. Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93

02864

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince George's  
City or town Hyattsville Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? nine years

Hospital, Institution, or street address where death occurred:  
Ayer Road, Rigg Farm, Hyattsville

How long in hospital or institution?

## 3. (a) FULL NAME

Lucinda Delaney

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

7

8

Widowed

6. (b) Name of husband or wife.

James Henry Delaney  
(deceased)

6. (b) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

1890

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Charles Co. Maryland

(Town, county, and state)

10. Usual occupation

Lived with daughter

11. Industry or business

Unemployed

MOTHER

FATHER

12. Name

Ely Ring

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mary Dent - (daughter)

Address

Ayer Road, Rigg Farm, Hyattsville Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Mar 27, 1946

(month) (day) (year)

Cemetery or crematory

John Wesley Cemetery

Location

Aquasco Md.

18. Funeral director

F. Gacki sons

Address

Hyattsville Md.

19. Date rec'd by registrar

May 26, 1946

James Severe

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Ayer Road, Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ayer Rd. Rigg Farm

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated that I attended deceased from Nov. 20, 1945 to March 27, 1946

and that I last saw her alive on March 23, 1946

Immediate cause of death Myocarditis

Acute

Paralysis - Rt. Side

Due to arteriosclerosis

Duration 1 month

5 days ago

7-8 yrs

Due to Age, work done in middle of

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

William H. Spiller M.D.

M. D. or other

Brentwood Md.

Date signed 3-24-46

RECEIVED

MAR 29 1946

BUREAU F.B.I.

Evidence for change of age  
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19102

02865

FILM No. I 01 APR 1 - 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County..... Pro Geo County  
City or town..... Cheverly Maryland.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 hrs 15 minutes

Hospital, Institution, or street address where death occurred:

Prince Georges Hospital

How long in hospital or institution? 23 hrs 15 minutes

3. (a) FULL NAME

George A Drury

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife..... Annie Drury

7. Birth date of deceased (mo., day, yr.) June 11 1876 6.(c) If alive, give age ..... years

8. AGE: Years 68 Months 69 Days 9 If less than one day  
..... hrs. ..... min.

9. Birthplace..... Maryland (Town, county, and state)

10. Usual occupation..... Chicken farmer

11. Industry or business

12. Name..... Thomas J. Drury

13. Birthplace..... Maryland

14. Maiden name..... Annie Gurtin

15. Birthplace..... Maryland.

16. Informant..... Mrs. Bonnie Wagner

Address..... Colmar Manor Maryland.

17. Burial Date thereof Mar 25, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Evergreen Cemetery

Location..... Bladensburg Maryland

18. Funeral director..... F. Gasch's Sons

Address..... Hyattsville Maryland.

19. 3/25 1946 Alexandra Drury  
(Date rec'd by registrar) Registrars

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland Pro Geo Co  
County.....

City or town..... 3416 39th st  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Colmar Manor Maryland

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 20 1946 to March 21 1946  
and that I last saw him alive on March 20 1946

Immediate cause of death Acute Pulmonary edema

DURATION 1 day

Due to Nephrosclerosis duration

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

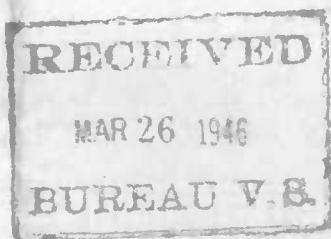
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Paul C Van Hatten M. D. or other

Address..... Washington 19 DC Date signed 3/23/46



**M**  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27

02866  
232

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

Prince George

City or town.....

Westwood  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

all his life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

Westwood

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored widow

Married

6. (b) Name of husband or wife

Mary P. Duckett

7. Birth date of deceased (mo., day, yr.)

May 1 - 1875

6. (c) If alive, give age..... years

8. AGE:

Years  
70Months  
10Days  
1If less than one day  
hrs. .... min.

9. Birthplace.....

Prince George

(Town, county, and state)

10. Usual occupation.....

Teacher

11. Industry or business

FATHER

12. Name.....

Richard Duckett

13. Birthplace.....

Md. (Westwood)

MOTHER

14. Maiden name.....

Jane Johnson

15. Birthplace.....

Md.

16. Informant.....

John P. Duckett

Address.....

Westwood Md

17. Burial

(Burial, cremation, or removal. Which?)

Brooklyn Cemetery

Date thereof.....  
(month) (day) (year)  
May 5 1946

Cemetery or crematory.....

Location.....

Taylors Md

18. Funeral director.....

Address.....

J. T. Johnson

19. Date rec'd by registrar

(Date rec'd by registrar)

1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. Prince George

City or town.....

Westwood, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Mar. 2 1946 at 5 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 23 1946 to Mar. 2 1946

and that I last saw him alive on Feb. 23 1946

DURATION

2 yrs

Immediate cause of death.....

Cerebral Sclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

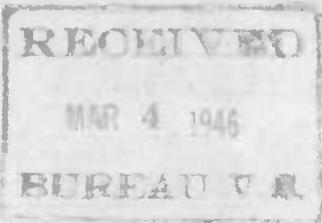
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... BrandYWINE, Md. Date signed 3/2/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

Reg. Diet. No. 02843

1. PLACE OF DEATH: Prince George's  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 12 days  
Hospital, institution, or street address where death occurred:  
..... Glenn Dale Sanatorium  
How long in hospital or institution?..... 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... D. C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3020 Dent Place N. W.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

DULIN, NORMAN M.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife..... Eleanor Duline (Dec.)

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1876

8. AGE:	Years	Months	Days	If less than one day
	69	5	26	hrs. min.

9. Birthplace..... Washington, D. C.  
(Town, county, and state)

10. Usual occupation..... Guard (retired - Govt.)

11. Industry or business

12. Name	James C. Duline
13. Birthplace	Washington, D. C.

14. Maiden name	? Hale
15. Birthplace	Washington, D. C.

16. Informant..... Decedent

17. Removal  
(Burial, cremation, or removal. Which?) Date thereof..... Mar. 25, 1946  
(month) (day) (year)

Cemetery or crematory..... Location to Washington, D.C.

18. Funeral director..... W.W. Chambers Co

Address 1400 Chapin St. N.W. Wash. D.C.

19. Mar. 24, 1946 Rowland S. Phillips  
(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 24, 1946, at 6:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/12 1946 to 3/24 1946

and that I last saw h. in alive on 3/24 1946

Immediate cause of death..... pulmonary tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

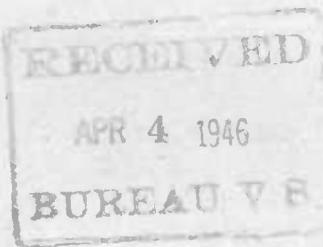
Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... Daniel Leo Fineane M.D.

M. D. or other.....

Address..... Glenn Dale, Md. Date signed..... 3/24/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No. 02864  
243

## 1. PLACE OF DEATH:

County... Prince George's

City or town... (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 10 mos., 4 days

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 10 mos., 4 days

## 3. (a) FULL NAME

Henry C Dunkins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife.....

Mary C. Dunkins

6. (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.)

June 18, 1903

8. AGE:

Years

Months

Days

If less than one day

42

8

18

hrs.

min.

9. Birthplace..... Stafford, Virginia

(Town, county, and state)

10. Usual occupation.....

Truck Driver

11. Industry or business

12. Name..... Henry Dunkins

13. Birthplace..... Widewater, Virginia

14. Maiden name..... Cornelia Coleman

15. Birthplace..... Widewater, Virginia

16. Informant..... Deceased

Address

17. Removal to..... Removal to (Burial, cremation, or removal. Which?)

Date thereof..... Mar 8, 1946  
(month) (day) (year)

Cemetery or crematory

Location..... Washington, D.C.

18. Funeral director..... Thomas Firaxier

Address..... 389 Radcliffe Ave. N.W., Wash. D.C.

19. (Date rec'd by registrar) Mar. 8, 1946 Rowland S. Phillips

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1741 T. St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

577-01-8153

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 8, 1946, at 10<sup>50</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4, 1944, to March 8, 1946,

and that I last saw him alive on March 8, 1946.

Immediate cause of death.....

Pulmonary Tuberculosis

25 mos.

Due to.....

Tubercular Laryngitis

7 mos.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Daniel Leo Pinecane M.D.

M. D. or other

Address..... Glenn Dale, Md. Date signed 3/8/46





# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

## Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	MAR 27 1946

BUREAU OF

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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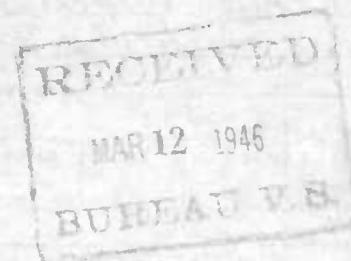
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RECEIVED TO TELETYPE STATE DEPARTMENT  
TELETYPE WIRELESS CO.  
RECEIVED NO. STATION 110



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

02871

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince George's.....  
 City or town..... (rural) Glenn Dale, Maryland.....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 yr., 4 mos., 6 days.....

Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium.....

How long in hospital or institution?..... 1 yr., 4 mos., 6 days.....

## 3. (a) FULL NAME

FLYNN STELLA G.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6. (b) Name of husband or wife..... Joseph D. Flynn (dec.).....

7. Birth date of deceased (mo., day, yr.)..... September 4, 1883.....

8. AGE: Years	Months	Days	If less than one day
62	6	18	hrs. min.

9. Birthplace..... Oil City, Pennsylvania.....  
(Town, county, and state)

10. Usual occupation..... Housewife.....

11. Industry or business

12. Name	Michael Geary
MOTHER FATHER	Ireland

13. Birthplace	Catherine Flanagan
MOTHER	Erie, Pennsylvania

14. Maiden name	
15. Birthplace	

16. Informant..... Decedent.....

Address

17. Removal Date thereof..... Mar. 22 1946.....  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... to Washington, D.C.....  
Funeral director..... W.W. Chambers Co.18. Funeral director  
Address..... 1400 Chapin St. NW-Wash.....19. Mar. 22 1946 Rowland & Phillips  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D. C. .... County.....  
 Washington.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 3750 Fordham Rd. N. W. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number  
None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 22 1946 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/6 1944 to 3/22 1946  
and that I last saw her alive on 3/22 1946.

Immediate cause of death.....

Pulmonary  
Tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

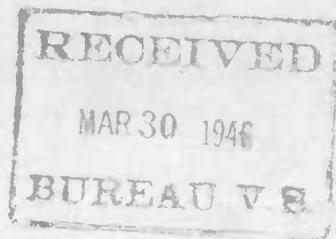
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Fineucane M.D. M. D. or other

Address..... Glenn Dale, Md. Date signed..... 3/22/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

02872

231

## 1. PLACE OF DEATH:

County... Prince George's  
City or town... Landover

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

6307 Osborne Drive

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

December 2, 1945

8. AGE: Years Months Days If less than one day

3 17

hrs. min.

9. Birthplace... Landover, Md.

(Town, county, and state)

10. Usual occupation... house

11. Industry or business

MOTHER FATHER 12. Name... unknown

13. Birthplace... unknown

14. Maiden name... Ida Foggins

15. Birthplace... Virginia

16. Informant... Ida Foggins

Address... Landover, Md.

17. Removal Date thereof... Mar. 19, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location... Washington, D.C.

18. Funeral director... Robert J. McGuire

Address... 1820-94 St New

19. 3/19 1946 Amada Daune

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George's

City or town... Landover

(If outside city or town limits, write RURAL and give nearest town)

Street No... 6307 - Osborne Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 19, 1946, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..., to 19..., and that I last saw him alive on 19...

Immediate cause of death...

Congestive heart failure  
Tuber

Due to... Tuber

Due to... Bronchopneumonia

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

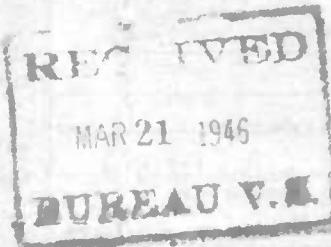
Fell into medical gear

23. SIGNATURE

M. D. or other

Address... Forest Hill road Date signed 3-19-46

Not on file



**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02873

## CERTIFICATE OF DEATH

Reg. Dist. No.

243.

## 1. PLACE OF DEATH:

County..... Prince George's

City or town..... (rural) Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 7 mos., 7 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 7 mos., 7 days

## 3. (a) FULL NAME

THOMAS, E FUNDERBURK

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife..... May L. Funderburk

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... 16 years

8. AGE: Years..... Months..... Days..... If less than one day  
43 2 - hrs. min.9. Birthplace..... Lancaster, South Carolina  
(Town, county, and state)

10. Usual occupation..... Salesman

## 11. Industry or business

FATHER 12. Name..... Thomas Funderburk  
13. Birthplace..... Lancaster, South CarolinaMOTHER 14. Maiden name..... Beulah Cameron  
15. Birthplace..... North Carolina

16. Informant..... Decedent

## Address

17. Removal to..... Date thereof..... 24 Mar 9 1946  
(Burial, cremation, or removal. Which?) Date (month) (day) (year)

## Cemetery or crematory

Location..... 139 N Potowmack St.  
Towson, Md.

## 18. Funeral director

Address..... Ted W. Grimes  
Signature, Md.19. Mar 9, 1946 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 1320 Harvard St. N. W.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

579-16-5505

## MEDICAL CERTIFICATION

2d. DATE OF DEATH..... March 9<sup>th</sup> 1946 at 3<sup>05</sup> M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 2<sup>nd</sup> 1945 to March 9<sup>th</sup> 1946  
and that I last saw him alive on March 9<sup>th</sup> 1946

## Immediate cause of death

Pulmonary Tuberculosis

Due to Pulmonary Hemorrhage

Due to fatal

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

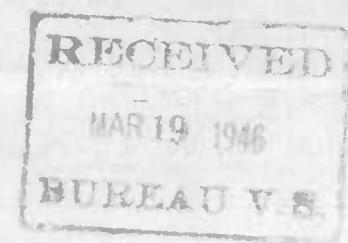
Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

23. SIGNATURE..... Daniel Leo Pinucare MD.  
M. D. or other

Address..... Glenn Dale, Md. Date signed 3/9/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

02874  
245

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:  
 County..... Prince Georges  
 City or town..... Riverdale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 19 hours  
 Hospital, Institution, or street address where death occurred:  
 Leland Memorial Hospital  
 How long in hospital or institution?..... 19 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... Maryland County..... Pr. Geo.  
 City or town..... Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 605 Ethan Allen Ave.  
 (If rural, give LOCATION)  
 Not  
 2.(a) If veteran, name war....

## 3. (a) FULL NAME

Gomez, Vincent Paul

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Virginia Katherine Gomez  
 6.(c) If alive, give age..... 37 years

7. Birth date of deceased (mo., day, yr.)..... July 14, 1909

8. AGE: Years Months Days If less than one day  
 36 8 16 hrs. min.

9. Birthplace..... New York City  
 (Town, county, and state)

10. Usual occupation..... Central Office Repairman

11. Industry or business..... The C. & P. Tel. Co.

MOTHER FATHER  
 12. Name..... Garcia Gomez

13. Birthplace..... Cuba

14. Maiden name..... Elizabeth E. Gomez

15. Birthplace..... Trinidad

16. Informant..... Virginia K. Gomez

Address..... 605 Ethan Allen Ave., Tak. Pk. Md.

17. Burial, cremation, or removal (Which?)..... Date thereof..... March 30, 1946  
 (month) (day) (year)

Cemetery or crematory..... Funeral Home  
 Location..... 2901 - 14th St. N.W. Wash. D.C.

18. Funeral director..... S. J. Jones Co.  
 Address..... 2901 14th St. N.W.

19. Date rec'd by registrar..... May 30, 1946  
 (Date rec'd by registrar) James Severe  
 Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 30, 1946 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 March 4th 1946 to March 30, 1946  
 and that I last saw him alive on March 30, 1946  
 Immediate cause of death..... Carcinoma of liver

DURATION..... 3 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Operation at Sibley Hospital  
 Date of op. May 1st, 1943 - Carcinoma of Liver

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Struck by a car while at work?

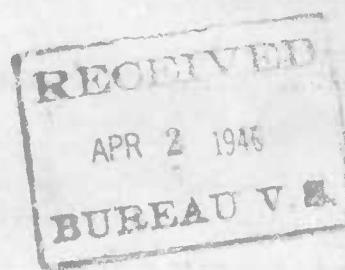
23. SIGNATURE..... John Kelly J. Brown  
 Delmer J. Brown, M.D. M.D. or other  
 Address..... 45 Carroll Ave. Tak. Pk. Md. Date signed..... 3/1/46

Mr. Goss  
Telecom Park  
800 E. Union Avenue  
Milwaukee

AOI:O DE 08 MARCH 30, 1946

DE 08 MARCH 30, 1946 MARCH 30, 1946  
DE 08 MARCH 30, 1946 MARCH 30, 1946  
CERTIFICATE OF JURISDICTION

3 Vols.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-a

## CERTIFICATE OF DEATH

02875

Reg. Dist. No.

237

1. PLACE OF DEATH: Pr. George  
 County Aquasco

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James McDaniel Gross  
 4. Sex m 5. Color or race Col. 6.(a) Single, married, widower, or divorced Married

B. (b) Name of husband or wife Nellie Gross

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1876 8. (c) If alive, give age years

8. AGE: Years 69 Months 4 Days 24 If less than one day hrs. min.

B. Birthplace Aquasco, Md. (Town, county, and state)

10. Usual occupation Chapman

11. Industry or business Private farm

12. Name Henry Gross

13. Birthplace Aquasco, Md.

14. Maiden name Charity Chapman

15. Birthplace Aquasco, Md.

16. Informant Collect & Banks

Address Aquasco, Md.

17. Burial Date thereof 3 / 14 / 46 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory John Wesley M. E.

Location Aquasco, Md.

18. Funeral director Health & Ryan

Address Meadow, Md.

19. Date rec'd by registrar July 9th 1946 Thos. H. B. Carter

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborns to age 1 give residence of mother)

State Maryland County R.P.

City or town Aquasco (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 1st 1946 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from fall 1942 to March 1st 1946,

and that last saw him alive on March 1st 1946.

Immediate cause of death Arterial thrombosis DURATION \_\_\_\_\_

Due to Arterio sclerosis \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Ch. intestinalis neglectus \_\_\_\_\_

(Indicate pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Richard Lee Silcox M. D. or other \_\_\_\_\_

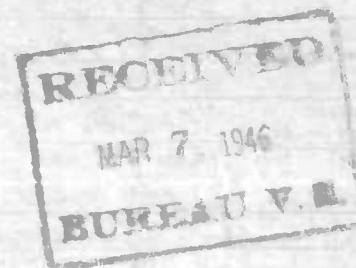
Address 3140 Glenelg Rd. Date signed 5-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ATTACH TO TRANSMISSION NO. 2 CHAPMAN

ATTACHED TO TRANSMISSION

LOAN



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

02876

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County

Geo Co

City or town

Hyattsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Rudolph Jack Guchik

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Clara a Guchik

7. Birth date of deceased (mo., day, yr.)

Dec 12, 1892

6. (c) If alive, give age

47

years

8. AGE:

53

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Chicago Ill

(town, county, and state)

10. Usual occupation

Mahomet

11. Industry or business

Navy Yard Washington D.C.

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Germany

14. Maiden name

Unknown

15. Birthplace

Germany

16. Informant

Clara a Guchik

Address

Hyattsville Md.

17. Burial

Date thereof: March 6, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Arlington Cemetery

Location

Va

18. Funeral director

F. Gards son

Address

Hyattsville Md.

19. Date rec'd by registrar

Mar 11

1946

James Severy

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md Pro Geo Co

City or town

Hyattsville Md.

Street No.

4209 - Greenbury Rd.

(If outside city or town limits, write RURAL and give nearest town)

(General, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH: March 3, 1946, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1943, to March 3, 1946,

and that I last saw him alive on March 3, 1946.

Immediate cause of death

Carcinoma of Liver

Carcinomatosis

Due to past food ms

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

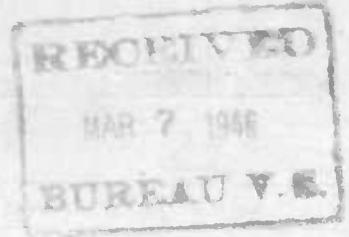
Means of injury

Injured at work?

23. SIGNATURE: John Severy

M. D. or other

Address: Hyattsville Md. Date signed: March 3, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct surname shown on Film G101  
is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of MARYLAND STATE DEPARTMENT OF HEALTH  
surname shown on Film G101 2411 N. Charles St., Baltimore 23  
4/4/46 dm. Birth Certificate. CERTIFICATE OF DEATH

02877

231

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County..... Prince George General Hospital  
City or town..... Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

Prince George General Hospital

How long in hospital or institution? 1 day

## 3. (a) FULL NAME

Warold - HARMAN

## 4. Sex

m

## 5. Color or race

w

## 6.(a) Single, married, widowed, or divorced

HARMAN

## 6.(b) Name of husband or wife

Evelyn - HARMAN

8.(c) If alive, give age years

## 7. Birth date of deceased (mo. day. yr.)

Feb. 19 1906

## 8. AGE:

Years	Months	Days	If less than one day
40	1	27	hrs. min.

## 9. Birthplace

(Town, county, and state)

Delaware

## 10. Usual occupation

Retired Accountant

## 11. Industry or business

HARMAN

## 12. Name

David - HARMAN

Pa.

## 13. Birthplace

## 14. Maiden name

Lula Baker

Pa.

## 15. Birthplace

## 16. Informant

Mrs. Evelyn HARMAN

## Address

4201 Russell St., Mt. Rainier

## 17. Removal

Date thereof Mar. 27, 1946

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

## Location

The S.H. River Co

## 18. Funeral director

Address 2901 14th St. N. W. Wash. D.C.

## 19. Date rec'd by registrar

3/27/46

19.

Amanda Duray

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Mt. Rainier (If outside city or town limits, write RURAL and give nearest town)

Street No. 4201 Russell St., Mt. Rainier (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-16-1943 to 3-27-1946

and that I last saw him alive on 3-26-1946

Immediate cause of death Rheumatic Heart Disease - Mental Stress

DURATION

25 years

Due to.....

Due to.....

Other conditions Acute Respiratory

Infection

(Include pregnancy within 3 months of death)

3 days

Major findings of operations

Date of op.

Autopsy results See cause of death

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

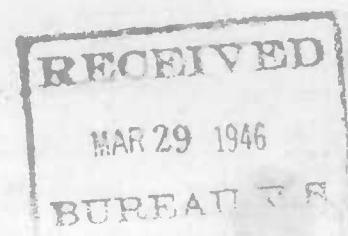
23. SIGNATURE

W. Brumley M.D.

M. D. or other

Address 3303 Quincy St. N.W. Washington, D.C. Date signed 3-27-46

not



## MARYLAND STATE DEPARTMENT OF HEALTH 03123

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County... Prince George's

City or town... Bradbury Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Edward Harrison

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Bertha May Harrison

B. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Not accurately known

8. AGE: Years Months Days If less than one day  
62 — — — hrs. — min.9. Birthplace Washington, D.C.  
(town, county, and state)

10. Usual occupation House Painter

11. Industry or business Painting for D.C.

MOTHER FATHER 12. Name Not known

13. Birthplace Washington, D.C.

14. Maiden name Not known

15. Birthplace Washington, D.C.

16. Informant M. E. Harrison

Address 4603 Shadyside Ave. Brad 145 Mo.

17. Burial Date thereof 3/30/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wash National

Location 4101 Segitland Rd. Md.

Funeral director Arthur N. Meloy

Address 522-8th St. Ste.

March 28 1946 James Severy

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Bradbury Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4603 Shadyside Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27<sup>th</sup> 1946 10:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 to March 27 1946

and that I last saw him on March 27 1946

Immediate cause of death Cardiac Arrest

Not accurately known

Due to Arteriosclerosis

Due to Age

Other conditions Cardiac Arrest - not known

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Arthur N. Meloy M.D. or other

Address 4400 Bonner Rd. 3-27-46 Date signed

APR 22 1946

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02878  
242

## CERTIFICATE OF DEATH

Reg. Distr. No. ....

## 1. PLACE OF DEATH:

County

City or town

Prayel Georges

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One year

Hospital, institution, or street address where death occurred:

2911 - Branch Ave NE

How long in hospital or institution?

## 3. (a) FULL NAME

Edward Sherman Howard

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widowed

6.(b) Name of husband or wife

Beula A. Howard

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 22, 1887

8. AGE:

Years  
58Months  
10Days  
9

If less than one day

hrs. min.

9. Birthplace

New York

(Town, county, and state)

10. Usual occupation

Astrophath

11. Industry or business

12. Name

Edward W. S. Howard

13. Birthplace

Canada

14. Maiden name

Susie Morton

15. Birthplace

Mass.

16. Informant

Edward William Howard

Address

7108-K H St. N.E. Wash DC

17. Burial

Date thereof Apr. 3 1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Wash. D.C. Sixthland

18. Funeral director

M. T. W. Agency Co

Address

300 N. H. N. H. Wash D.C.

19. Date rec'd by registrar

3-31-

1946

(Date rec'd by registrar)

V / Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h... alive on 19.

Immediate cause of death

Acute Congestive heart failure

Due to Cardiosascular cerebral disease

DURATION

Due to

Other conditions Acute alcoholism

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

deputy medical examiner

23. SIGNATURE Date signed M. D. or other

J. V. Ford

Forest Hill

Date signed 3-31-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 120-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

Prince George  
Cheverly, Md  
City or town  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution?

4 days

4 days

## 3. (a) FULL NAME

Clarence Hoyt

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

1

8. (b) Name of husband or wife

Carrie Hoyt.

7. Birth date of deceased (mo., day, yr.)

May 26 - 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

57

10

24

hrs.

min.

9. Birthplace

(Town, county, and state)

Pa.

10. Usual occupation

Type operator.

11. Industry or business

Willard Hoyt

12. Name

Willard Hoyt

13. Birthplace

Pa.

14. Maiden name

Sally

15. Birthplace

Pa.

16. Informant

Mrs. Carrie Hoyt

Address 4317 Newark Road, Colmar Manor, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Mar 27, 1946

Cemetery or crematory

Fort Lincoln

Location

Colmar Manor, Md

18. Funeral director

J. Gocha Sons

Address

Hyattsville, Md

19. Date rec'd by registrar

3/24

1946

Amanda Journe

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Colmar Manor  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4317 Newark Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2d. DATE OF DEATH

March 24 1946 at 2:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 20 1946 to Mar. 24 1946

and that I last saw h.i.m. alive on Mar. 24 1946

Immediate cause of death

Chronic ulcerative colitis,  
hemorrhage

DURATION

Due to

Due to

Other conditions Chronic atrophic  
ulcerative gastritis  
(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

Scarred

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

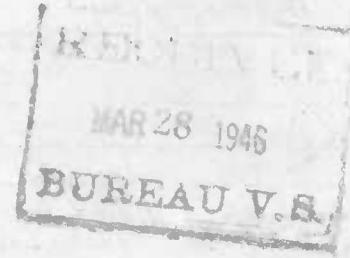
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John J. Maloney, M.D. M. D. or other

Address Hyattsville, Md Date signed 3-25-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

02880  
242

## CERTIFICATE OF DEATH

Reg. Dlat. No. ....

## 1. PLACE OF DEATH:

County Talbot Co.  
City or town Talbot Island  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 daysHospital, institution, or street address where death occurred: 54th Lane

How long in hospital or institution?

## 3. (a) FULL NAME

Bernard Cordell Johnson  
4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

## 8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 5, 1915  
6.(c) If alive, give age years

8. AGE: Years 1 Months 8 Days 0 If less than one day  
hrs. 0 min. 0

9. Birthplace Washington DC  
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Bernard Johnson13. Birthplace Washington DC14. Maiden name Lelia Mae Russell15. Birthplace Maryland16. Informant Bernard JohnsonAddress Talbot Island, MD17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 13-46

(month) (day) (year)

Cemetery or crematory

Location Washington DC18. Funeral director John StevensAddress 30 37th St. NE19. (Date rec'd by registrar) 1/15/46 19. (Date) 1/16/46 Carrie F. Campbell  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Talbot Co.  
City or town Talbot Island  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 54th Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1946 at 8 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on 19, to 19.

Immediate cause of death

asphyxia  
Due to Asphyxia of mother

Due to Asphyxia of mother

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Data of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

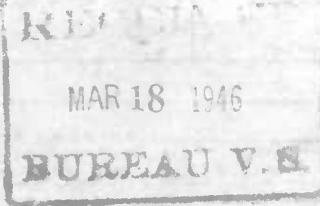
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Talbot Island Date of 1/13-46 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Motor vehicle accident Injured at work? NoReceiving medical treatment Yes23. SIGNATURE Carrie F. Campbell M. D. or otherAddress Hospital Hill 211 Date signed 1/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02881

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:  
County..... Prince George's  
City or town..... Cedar Heights  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 20 years  
Hospital, institution, or street address where death occurred:..... 1007 62nd Ave.  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Prince George's  
City or town..... Cedar Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 1007 62nd Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... World War # 1

## 3. (a) FULL NAME

Jacob Johnson

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White <i>Colored</i>	Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) ..... August 8, 1989

8. AGE:	Years	Months	Days	If less than one day ..... hrs. .... min.
	56			

9. Birthplace..... Virginia  
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

12. Name	Henry Johnson
13. Birthplace	Va.

MOTHER FATHER	14. Maiden name	Lucy Mauns
	15. Birthplace	Va.

16. Informant	Geneva Henderson
Address	1003 62nd Ave., Cedar Heights

17. Removal	Date thereof	Mar 6 1946
(Burial, cremation, or removal, which?)	(month)	(day)

Cemetery or crematory	Washington Funeral Home
-----------------------	-------------------------

Location	Washington, D.C.
----------	------------------

18. Funeral director	J. J. Gasch Sons
Address	Ayottsville, Md.

19. Date rec'd by registrar	1946	3/6	Amelia Douras
(Date rec'd by registrar)			

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. .... to 19. ....

and that I last saw h. .... alive on 19. ....

Immediate cause of death..... Acute congestive heart failure

Due to..... Cardiovascular renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

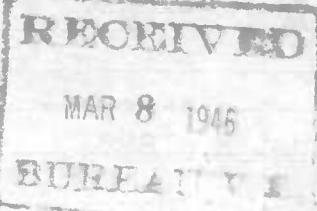
Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

Deputy Medical Examiner

23. SIGNATURE James J. Gasch M. D. or other

Address..... Forestville Md. Date signed 3-6-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

02882

## CERTIFICATE OF DEATH

Reg. Dist. No.

245

## 1. PLACE OF DEATH

County

Grand George

City or town

Glenelg Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

47 days

Hospital, institution, or street address where death occurred:

4408 - Queen'sbury Road

How long in hospital or institution?

47 days

## 3. (a) FULL NAME

Edward A. Keefer

4. Sex

m

5. Color or race

white

6.(a) Single, married, widowed, or divorced

m

6.(b) Name of husband or wife

Mrs. Gertrude Dally Keefer

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.)

Jan 1, 1883

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

MOTHER FATHER

Joseph Ossac Keefer

12. Name

Virginia

13. Birthplace

Philadelphia E. Winfield

14. Maiden name

Virginia

15. Birthplace

Philadelphia

16. Informant

Leland Memorial Hosp.

Address

4408 Queen'sbury Road

17. Removal

Removal

Date thereof MAR 25 46

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Washington D.C.

Location

W.H. Chambers C.

18. Funeral director

H.W. Chambers C.

Address

517-11 1st St. S.E.

Date rec'd by registrar

James Severy

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C.

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3225-12 th St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 25

1946

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 19 1946

to

Mar 25

1946

and that I last saw him alive on

Mar 24

1946

Immediate cause of death

Congestive failure

Due to

Hypertensive cardiac disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

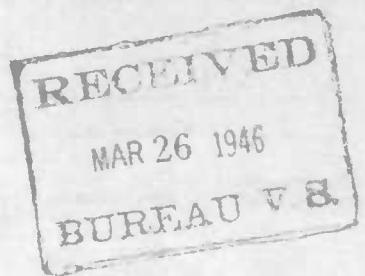
Henry J. Hadley

M. D. or other

Address

1556-68 Morris

Date signed .....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

02883

## CERTIFICATE OF DEATH

Reg. Dist. No. 2445

## 1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred: Deland Memorial Hospital

How long in hospital or institution? 6 days

## 3. (a) FULL NAME

Mr. John Alexander Kennedy

4. Sex Male 5. Color or race White 6. (c) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1874

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
72 1 14 hrs. min.9. Birthplace Baltimore Md.  
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Standard Oil Co.

12. Name John Joseph Kennedy

13. Birthplace Ireland

14. Maiden name Mary Ann Boyd

15. Birthplace Ireland

16. Informant Deland Memorial Hospital Record

Address Riverdale, Md.

17. Removal Date thereof 3-26-46

(Burial, cremation, or removal, when)

(month) (day) (year)

Cemetery or crematory Bethesda

Location Maryland

18. Funeral director W. H. R. Sumpfrey

Address Bethesda, Maryland

19. Date rec'd by registrar March 26 1946 James Severy

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 Carroll Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 26, 1946, at 11 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15, 1946, to March 26, 1946,

and that I last saw him alive on Mar 25, 1946.

## Immediate cause of death

Wheezing &amp; bronchopneumonia

## Due to

Arteriosclerotic Cordio-

vascular disease c

hemiplegia

Other conditions Prosthetic hypertension

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

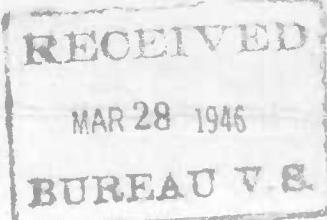
Means of injury Injured at work?

## 23. SIGNATURE

Beverland Turkelson, M.D. M. D. or other

Address 4404 Greenbury Rd. Date signed Mar 26, 1946

Riverdale Md.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

## CERTIFICATE OF DEATH

02881  
245  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Berwyn, Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ResidenceHospital, Institution, or street address where death occurred:  
5018 Quebec St.

How long in hospital or institution?

## 3. (a) FULL NAME

Clarence Wayne Knotts

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Mary Ethel Knotts8. (c) If alive, give age 55 years7. Birth date of deceased (mo. day, yr.) Aug. 6, 18898. AGE: Years 56 Months 6 Days 25 If less than one day  
hrs. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Indiana  
(Town, county, and state)10. Usual occupation State Police

11. Industry or business

12. Name Franklin Knotts13. Birthplace Indiana14. Maiden name Lenora Lee15. Birthplace Indiana16. Informant Hospital RecordsAddress Burial17. Date thereof March 5, 1946  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Arlington Va.18. Funeral director Dr. W. Chambers Co.Address Riverdale Md

March 3 1946 James S. Every

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Berwyn, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5018 Quebec St.  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2 1946 at 1:17 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 1945 to Mar 2 1946and that I last saw him alive on Mar 1 1946

Immediate cause of death

Bronchogenic carcinoma of rt. Bronchus

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings or operations

Cat. w/ no bony metastasis  
Autopsy results rigorous metastasis  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work \_\_\_\_\_

23. SIGNATURE L. C. Malin MD M. D. or other \_\_\_\_\_Address Riverdale, Md Date signed 3-3-46

RECEIVED  
MAR 5 1946  
BUREAU V R

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

## CERTIFICATE OF DEATH

02903232  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 year

Hospital, institution, or street address where death occurred:

Cain Highway

How long in hospital or institution?

## 3. (a) FULL NAME

Merle Florence Larson

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FemaleWhiteSing

6.(b) Name of husband or wife

6.(c) If alive, give age .....

years

7. Birth date of deceased (mo., day, yr.)

Aug 13, 1929

8. AGE:

Years 16

Months

Days

If less than one day

..... hrs. ..... min.

9. Birthplace

Jamestown, N.Y.

(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

Acy Larson

12. Name

Merle Larson

13. Birthplace

Sweden

14. Maiden name

Florence Matheson

15. Birthplace

Ohio

16. Informant

Acy Larson

Address

Upper Marlboro Hwy

17. Burial

BurialDate thereof 3-30-46  
(month) (day) (year)

Cemetery or crematory

St. Thomas

Location

Broom, Md.

18. Funeral director

Petrie Brothers

Address

Upper Marlboro, Md.

19. Date rec'd by registrar

March 29, 1946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. Cain Highway  
(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Acute congestive  
Heart failure  
Myocarditis

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

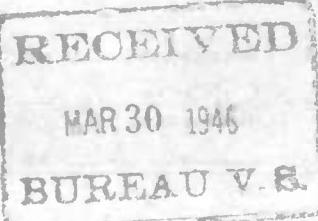
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?  
Hospitalized during

23. SIGNATURE

John  
Dorrell M. D. or other  
Date signed 3-28-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02885

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County Prince George's

City or town (If outside city or town limits, write RURAL and give nearest town) Rural) Glenn Dale, Maryland

How long in above place of death? 4 mos., 16 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 4 mos., 16 days

## 3. (a) FULL NAME

LEACH, TIRSEY, L

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Colored Married

6.(b) Name of husband or wife Allen Leach

7. Birth date of deceased (mo., day, yr.) May 8, 1917 6.(c) If alive, give age 29 ? years

8. AGE: Years Months Days If less than one day  
28 10 14 hrs. min.9. Birthplace Lumberton, North Carolina  
(Town, county, and state)

10. Usual occupation Housework

## 11. Industry or business

FATHER 12. Name Fred Thompson  
13. Birthplace Lumberton, North CarolinaMOTHER 14. Maiden name Annie Pharr  
15. Birthplace Lumberton, North Carolina

## 16. Informant Decedent

## Address

17. Removal Date thereof Mar. 22, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

## Cemetery or crematory

Location to Washington, D.C.

18. Funeral director Malvan &amp; Sibley Inc.

## Address

124 - R St NW

19. Mar. 22, 1946 Rowland & Phillips  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C.

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1029 - 22nd St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

?

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 22, 1946, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/6 1945 to 3/22 1946  
and that I last saw her alive on 3/22 1946

## Immediate cause of death

Tuberculosis  
peritonitis  
pulmonary

## Due to

tuberculosis

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

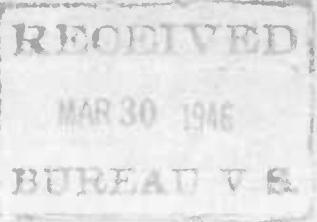
Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Daniel Leo Finegan MD.  
M. D. or other  
Address Glenn Dale, Md. Date signed 3/22/46



02886

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County..... Prince George's  
 City or town..... (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 mo. 8 days

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 1 mo. 8 days

## 3. (a) FULL NAME

SING FUN LEE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Chinese	Married

6.(b) Name of husband or wife..... Neh Shee

7. Birth date of deceased (mo., day, yr.) January 17, 1882

8. AGE: Years	Months	Days	If less than one day
64	1	19	hrs. min.

9. Birthplace..... Yuma City, California  
 (Town, county, and state)

10. Usual occupation..... Laundry Proprietor

## 11. Industry or business

12. Name..... Men Lee

13. Birthplace..... China

14. Maiden name..... Shee Wong

15. Birthplace..... China

16. Informant..... Deceased

## Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof..... Mar 17, 1946

Cemetery or crematory..... Fort Lincoln Cemetery  
 Location..... Boulevard & District Line, Prince George's Co. Md.

18. Funeral director..... J. W. Lee's Sons

Address..... 300-4th St NE

19. Date rec'd by registrar..... Mar 8, 1946 Rowland S. Phillips  
 Registrar.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)Street No..... 740 - 6th St. N. W.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Mar. 8, 1946 at 9:43 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 28, 1946, to Mar. 8, 1946

and that I last saw him alive on Mar. 8, 1946

## Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

8 mo.

## Due to..... Complication

Diabetes Mellitus

1 1/2 mo?

## Due to.....

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op. ....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

## Means of injury.....

Injured at work? .....

## 23. SIGNATURE..... Daniel Leo Finegan MD.

M. D. or other

Address..... Glenn Dale Md. Date signed..... Mar 8/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02887

245

## CERTIFICATE OF DEATH

Reg. Date. No.....

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 1/2 years

Hospital, institution, or street address where death occurred:

410 1/2 Gallatin St.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Marcus Winfield Lewis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

7. Name of husband or wife

Catherine Turner Lewis

8. AGE: Years Months Days If less than one day

84 10 29 hrs. min.

9. Birthdate

Apr. 13 1861

10. Usual occupation

Civil engineer

11. Industry or business

Retired since July 1932

12. Name

John Stealer Lewis

13. Birthplace

Albany County N.Y.

14. Maiden name

Catharine Kennedy Campbell

15. Birthplace

Penn.

16. Informant

Ely A. Lewis

Address

410 1/2 Gallatin St. Hyattsville Md

17. Cremation

Date thereof

May 2 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Leer Crematorium

Location

Ward 59

P.W.M. Ice's Sons Co

18. Funeral director

300-4 St. N.E. Washington

Address

Howard T Morse and

James Berry

Registrar

March 2 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

Mar 2 1946 at 5:44 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 6 1932 to Mar 2 1946

and that I last saw him alive on Dec 21 1946

Immediate cause of death

Heart Block

Due to Chi Ray Myocarditis

Duration 7 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Address

Howard T Morse and

James Berry

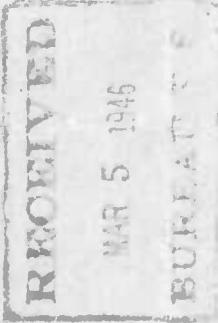
M.D. or other

Address

Howard T Morse and

James Berry

Date signed



Prince George County Police notified and  
Released by Mr. Boyd. Prince George Coroner.

D. T. Shonehan

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

02888

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County... Prince George's  
City or town... Capital Heights  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

602 - 61st Ave

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

6.(b) Name of husband or wife.....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

Aug 13, 1945

8. AGE:

Years	Mouths	Days	If less than one day
6	8	22	hrs. min.

9. Birthplace.....

Bethesda Md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name... Edmund Stanley Lipocki (Steve)

13. Birthplace Illinois

14. Maiden name Margaret Agnes Shelly

15. Birthplace Vicksburg

16. Informant Mrs Margaret A. Lipocki

Address 602 - 61st Ave. Capital Heights

17. Burial Date thereof Mar 7-46

(Burial, cremation, or removal? Which?)

Cemetery or crematory Ft Lincoln Cem

Location Prince Geo. Co. Md.

18. Funeral director C. W. Chambers Co

Address 517-11th St. S.E. Wash. DC

19. 3-5 1946 Carrie F. Campbell

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County Prince George's

City or town... Capital Heights  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 602 - 61st Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. .... to 19. ....

and that I last saw h. alive on 19. ....

Immediate cause of death

Sofaria

DURATION

Due to Bronchopneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

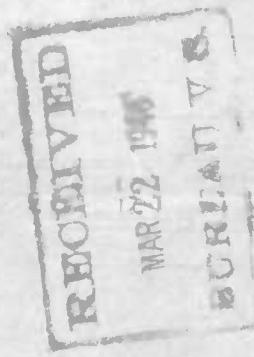
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Recreational medical Examiner

23. SIGNATURE James J. Bond M. D. or other

Address Forestville Park Date signed 3-5-46



Copy sent to Co. H. D. 3/22/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13d

02889

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

60 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Bernard Adams Trauner

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Widower

6.(b) Name of husband or wife.....

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

March 2, 1859

8. AGE:

Years

Months

Days

If less than one day

87

16

hrs.

min.

9. Birthplace.....

Balto Co Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Retired Farmer

MOTHER

FATHER

12. Name.....

Bernard Adams

13. Birthplace.....

Baltimore

14. Maiden name.....

Bernard

15. Birthplace.....

Baltimore

16. Informant.....

Bernard Adams

Address

Baltimore Md

17. Burial.....

Burial

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Acreview

Location.....

Baltimore Co Md

18. Funeral director.....

Martin Fladung Sons

Address

Baltimore Md

19. (Date rec'd by registrar)

March 24, 1946 Mrs J. W. Yingling

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Prince George

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 22 1946 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 29, 1944, to March 22, 1946

and that I last saw deceased alive on March 22, 1946

Immediate cause of death, liver disease inoperable DURATION

5 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

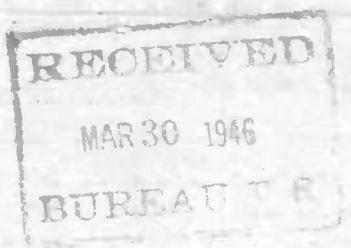
Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Frank J. Fladung Jr. Date signed 3/25/46



Evidence for change of year MARYLAND STATE DEPARTMENT OF HEALTH  
of birth of deceased is shown on 2411 N. Charles St., Baltimore

02891

FILM No. 101 APR 16 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County

Pro. Geo co.

City or town

Elkberry Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Pro George Hospital

How long in hospital or institution?

2 days

3. (a) FULL NAME

Hella Marshall

3. (b) Social Security Number

4. Sex

Female

5. Color of race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Herman L. Marshall

7. Birth date of deceased (mo., day, yr.)

Sept 1, 1886 1866

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

New Hampshire

(Town, county, and state)

10. Usual occupation

house wife

11. Industry or business

Castel McFarland

FATHER

12. Name

Mose

MOTHER

13. Birthplace

Lucy Lane

14. Maiden name

unknown

15. Birthplace

M Murray Marshall (son)

16. Informant

Elkberry Md.

Address

transcription Mar 30, 1946

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

17. Funeral director

Address

18. Date rec'd by registrar

Registrar

19. M. D. or other

Date signed

Address

20. Reg. Dist. No.

21. County

22. State

23. City or town

24. Street No.

25. Zip code

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

Nyatterville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

5303 Annadale Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1946 a.m. 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 22 1946 to Mar. 28 1946

and that I last saw h. u. alive on Mar. 28 1946

Immediate cause of death

trauma

Due to

Cardio renal vascular

Due to

Hypertension

myocardiosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

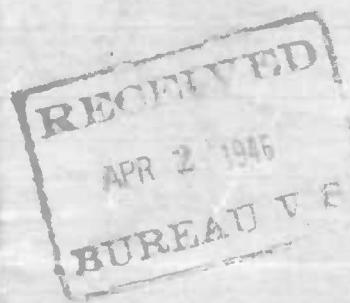
Injured at work? .....

23. SIGNATURE Wm H. Norton

M. D. or other

Address 3837-34st McLean

Date signed 3-28-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

02890

Reg. Dist. No. 242

## CERTIFICATE OF DEATH

### 1. PLACE OF DEATH:

County

Prince George  
Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

City or town  
How long in above place of death? 8 yrs.  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Joseph Clovis G. Merriam

### 3. (b) Social Security Number

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

M.

W.

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 12 - 1879

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

66 8 12

.hrs. min.

9. Birthplace

Pittsfield Mass.

(Town, county, and state)

10. Usual occupation

Supt Willow Mills

Retired

11. Industry or business

12. Name

Joseph Merriam

13. Birthplace

14. Maiden name

?

15. Birthplace

?

16. Informant

Mrs Grace Walker

Address

106 Eldon Drive Alexandria Va

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Washington D.C.

Cemetery or crematory

Location

641-14 St. N.E. Washington D.C.

18. Funeral director

Albert F. Clark

Address

641-14 St. N.E. Wash D.C.

19. Date rec'd by registrar

3/24/46

19. Date signed

Carrie F. Campbell

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Prince George

City or town

Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.

6206 Lady Side Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH

24 March 1946, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 July 1944, to 24 March 1946

and that I last saw him alive on 8 March 1946

Immediate cause of death

Coronary thrombosis

DURATION

10 minutes

Due to

Arterio-sclerosis

3 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

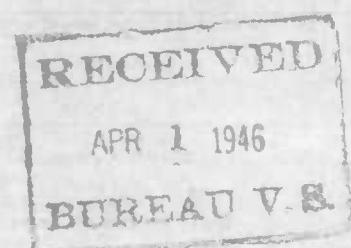
Means of injury Injured at work

23. SIGNATURE

Harvey K. Ammenman M. D. or other

Address 5440 Silver Hill Rd. Date signed 24 March 1946

Lithland



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1256

## CERTIFICATE OF DEATH

02892  
Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 25 days

## 3. (a) FULL NAME

Milar, Mrs. Helen

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Milar, Mr. Howard

6.(c) If alive, give age years

Oct. 4, 1909

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day  
hrs. min.

36

5

26

9. Birthplace

U.C.

(Town, county, and state)

10. Usual occupation

H.W.

11. Industry or business

FATHER

12. Name Billingsley, Rev. J. H.

13. Birthplace Va.

MOTHER

14. Maiden name George, Edith

15. Birthplace Va.

16. Informant

Milar, Mr. Howard (Husband)

17. (Burial, cremation, removal, Which?) Removal

Date thereof Mar. 31, 1946

(month) (day) (year)

Cemetery or crematory

Removed to Bethesda

Location

Brenton Pumphrey

18. Funeral director

Bethesda, Md.

Address

March 31, 1946

19. (Date rec'd by registrar)

Amanda Lourie

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Prince George

City or town Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3005 Taylor Street

at rural, give LOCATION

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31

1946 at 2<sup>55</sup>A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 23 1946 to Mar. 31 1946

and that I last saw her alive on Mar. 31 1946

Immediate cause of death

Primary abscess &amp; liver

DURATION

6 weeks

Due to streptococcal septicemia

6 weeks

Due to

Other conditions. subdiphtheritic abscess

(Include pregnancy within 3 months of death)

Major findings of operations. subdiphtheritic abscess

Date of op. 3/25/46

Autopsy results. liver abscess

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John M. Groves, M.D. M.D. or other

Address Mt. Rainier, Md. Date signed 3/31/46

RECEIVED

APR 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3d

02893

## CERTIFICATE OF DEATH

Reg. Dist. No. 240

## 1. PLACE OF DEATH:

County.....

Daggett Georges  
Rocketham, Md

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Francis Edgare Mudd

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white single

6. (b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.)

November 28, 1892

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

53

3

18

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Waldorf, Calvert Co., Md

10. Usual occupation.....

farmer

11. Industry or business

12. Name.....

Bernard A. Mudd

13. Birthplace

Prince Georges Co., Clinton, Md

14. Maiden name.....

Frances Edith Maud Mudd

15. Birthplace

Waldorf, Calvert Co., Md

16. Informant.....

Bernard A. Mudd Jr

Address

Brandywine, Md

17. Burial

Burial Date thereof..... 3-21-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Upper Marlboro, Md

Location

Mount &amp; Roy

18. Funeral director.....

Waelday, Md

Address

Brandywine, Md

19. Mar. 20 1946 F. J. Billingslee

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Prince Geo

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 18, 1946, 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 9, 1946, to March 18, 1946, and that I last saw him alive on March 18, 1946.

Immediate cause of death.....

Lobar pneumonia . 10 days

Due to.....

Influenza . 2 weeks

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Middletown Major findings or operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

John E. Powers, M.D. M. D. or other

Address

Brandywine, Md. Date signed 3/18/46

RECEIVED

MAR 25 1946

BUREAU V.S.

Evidence for change of year MARYLAND STATE DEPARTMENT OF HEALTH  
of birth of deceased is shown on 2411 N. Charles St., Baltimore 460

FILM No. I 01 APR - 9 1946

# CERTIFICATE OF DEATH

02894

245

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

City or town.....

Fairfax George

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Edward Mallory O'Brien

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Sept. 27, 1891

1890

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Florida

10. Usual occupation.....

dentist

11. Industry or business

MOTHER FATHER

12. Name.....

J. Ed. C. O'Brien

13. Birthplace

Florida

14. Maiden name.....

Cathasine Long

15. Birthplace

Alabama

16. Informant.....

Mrs. J. H. Johnson

Address.....

3502 Perry St.

17. Burial

(Burial, cremation, or removal, when?)

Date thereof.....  
(month) (day) (year)

Cemetery or crematory.....

Fort Lincoln

Location.....

Wash. Blvd. &amp; District Line

18. Funeral director.....

Mr. J. Walker

Address.....

3200 - P.O. Ave. Mt. Rainier Md.

19. Date rec'd by registrar.....

March 28

1946

James Seay

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Prince George

City or town.....

Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3502

Perry Street

(If rural, give LOCATION)

World War I

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 26 1946 at 7:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-16 1945 to 3-26 1946

and that I last saw him alive on

3-26 1946

Immediate cause of death.....

Cerebral hemorrhage

Secondary, colitis, micturition

Regurgitation &amp; tetanic convulsions

DURATION

9 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings at operations.....

Coccyx &amp; Prostate, Colon Intestinal obstruction

Date of op. 10-18-29 45

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

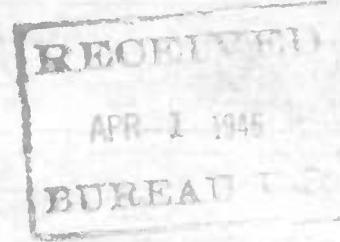
Injured at work?

23. SIGNATURE.....

Leverett Rogers M.D.

M. D. or other

Address..... Mt. Rainier Md. Date signed 3-27-46





**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

**2411 N. Charles St., Baltimore**

02895

## **CERTIFICATE OF DEATH**

**Reg. Dist. No.**

۲۷۳

1. PLACE OF DEATH: County City or town (If outside city or town limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State City or town (If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death? Hospital, institution, or street address where death occurred:			
How long in hospital or institution?			
3. (a) FULL NAME <i>Maggie Oden</i>		3. (b) Social Security Number	
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced <i>Married</i>	
6. (b) Name of husband or wife <i>Mary Oden</i>		7. Birth date of deceased (mo., day, yr.) <i>7 1867</i>	
8. AGE: Years <i>79</i>		Months	Days 11 less than one day
		hrs.	min.
9. Birthplace (Town, county, and state) <i>Upper Marlboro, Md.</i>		10. Usual occupation <i>At home</i>	
11. Industry or business <i>Madison Forbes</i>		12. Name <i>P. G. Co., Md.</i>	
13. Birthplace <i>P. G. Co., Md.</i>		14. Maiden name <i>Martha</i>	
15. Birthplace <i>P. G. Co., Md.</i>		16. Informant <i>Maggie Oden (Son)</i>	
Address <i>Baltimore, Md.</i>		17. Burial (Burial, cremation, or removal) Which? <i>Burial</i> Date thereof (month) (day) (year) <i>3-6-46</i>	
Cemetery or crematory <i>Rosaryville</i>		Location <i>Rosaryville, Md.</i>	
18. Funeral director <i>Fraternal Brothers</i>		Address <i>Upper Marlboro, Md.</i>	
19. (Date rec'd by registrar) <i>March 6 1946</i>		Registrar <i>Constance</i>	
2. MEDICAL CERTIFICATION			
20. DATE OF DEATH <i>March 3 1946</i> , at <i>6:00 PM</i>			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>Jan 10 1946</i> to <i>Mar 2 1946</i> and that I last saw her <i>alive</i> on <i>Mar 2 1946</i> .			
Immediate cause of death <i>Confusing Heart Failure</i>			
Due to <i>Cardio-vascular Syphilis</i>			
Due to <i>Arteriosclerosis</i>			
(Include pregnancy within 3 months of death)			
Major findings of operations <i>None</i>			
Autopsy results <i>No</i>			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of.....			
Where did injury occur? (City or town) (County) (State)			
Injured at home, farm, industry, public place (where?)			
Means of injury Injured at work?			
23. SIGNATURE <i>James B. Fawcett</i> M. D. or other Address <i>Upper Marlboro</i> Date signed <i>3-5-46</i>			

MARGIN RESERVED FOR BINDING

I

8

VS A15

RECEIVED

MAR 8 1946

BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

## CERTIFICATE OF DEATH

02896 231  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Pro Geo Co  
City or town..... Bladensburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Norris Winfield Payne

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Kate W. Payne

7. Birth date of deceased (mo., day, yr.) Jan 22, 1886

8. AGE: Years	Months	Days	If less than one day
60	1	18	hrs. min.

9. Birthplace..... Bladensburg Maryland  
(Town, county, and state) Cooper

10. Usual occupation.....

11. Industry or business Standard Brands Inc.

12. Name..... Milton J. Payne

13. Birthplace..... Virginia

14. Maiden name..... Edith E Shaw

15. Birthplace..... Maryland.

16. Informant..... Emily E. Payne

Address..... 5017 Quincey st Bladensburg Md.

17. Burial

Date thereof..... Mar. 12, 1946  
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Evergreen Cemetery

Location..... Bladensburg Maryland

18. Funeral director..... F. Gasch's Sons

Address..... Hyattsville Maryland.

19. 3/12 1946  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Pro Geo Co  
City or town..... Bladensburg Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 5017 Quincey Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 10 1946 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... Acute congestive heart failure DURATION

Due to..... Cardiovascular renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

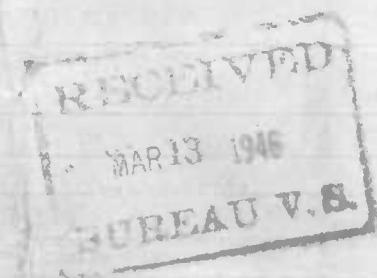
Injured at work? .....

Deputy Medical Examiner

23. SIGNATURE..... James J. Doyle

M. D. or other

Address..... Forestville Ind. Date signed..... 3-11-46





**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

10

VSA 15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02897

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

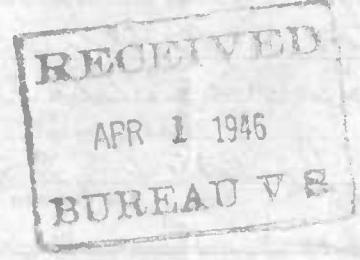
245

1. PLACE OF DEATH:	<i>Dr. Geo. C. County</i>
City or town:	<i>Tadoussac Park, N.B.</i>
(If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death?	.....
Hospital, Institution, or street address where death occurred:	.....
How long in hospital or institution?	.....

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)

State..... Ind County Perry Co.  
City or town. Takoma Park Ind.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 509 Ethan Allen Ave.  
(If rural, give LOCATION)

3. (a) FULL NAME			
<u>William S. Plager</u>			
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
<u>m</u>	<u>or</u>	<u>widowed</u>	
6. (b) Name of husband or wife			
<u>Jennie S. Plager</u>			
7. Birth date of deceased (mo., day, yr.)			
<u>July 14-1859</u>			
8. AGE: Years Months Days If less than one day			
<u>86</u> ..... hrs. .... min.			
9. Birthplace			
<u>Petersburg West Va.</u> (Town, county, and state)			
10. Usual occupation			
<u>Retired Builder</u>			
11. Industry or business			
<u>John Plager W.o.a</u>			
MOTHER FATHER	12. Name		
	13. Birthplace	<u>W.Va.</u>	
14. Maiden name			
<u>Selma Kelly</u>			
15. Birthplace			
<u>W.Va.</u>			
16. Informant			
<u>Nellie B. Metler</u>			
Address <u>509 Ethan Allen Ave</u>			
17. Burial		Date thereof	<u>3 - 29-46</u>
(Burial, cremation, or removal. Which?)		(month)	(day)
Cemetery or crematory			
<u>Glenwood Cemetery</u>			
Location <u>Wash. St.</u>			
18. Funeral director			
<u>Towchancos Co</u>			
Address <u>Riversdale, Md.</u>			
19. Date rec'd by registrar		<u>16</u>	<u>James Seay</u>
(Date rec'd by registrar) <u>Registra</u>			





# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

## Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	MAR 16 1928	1 week ago
Run over by street car		1 week ago
Peritonitis	(initials)	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02899

## CERTIFICATE OF DEATH

Reg. Dist. No.

239

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Davis Home for Children

How long in hospital or institution?

## 3. (a) FULL NAME

Marilyn Jeannine Robinson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Baby

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

June 1 - 1946

6.(c) If alive, give age years

## 8. AGE:

Years Months Days If less than one day  
2 1 . hrs. min.

## 9. Birthplace

Washington D.C.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

Thomas F. Robinson

Philadelphia, Pa.

## 14. Maiden name

Mabel Smith

Philadelphia

Mrs Francis Gregor

Mrs Davis Home -

Burial

Date thereof: May 2 46  
(Burial, cremation, or removal. Which?)

## Cemetery or crematory

Joy Hill

## Location

Laurel Md.

## 18. Funeral director

Lloyd Kaiser

## Address

Laurel Md.

March 2 46

(Date rec'd by registrar)

Cora E. Wachter

Signature

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D.C.

County

City or town

Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2348 Park St SE

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 1 1946 at P.A.M.

## 21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 14 1946 to March 1 1946

and that I last saw her alive on Feb 28 1946

## Immediate cause of death

Malnutrition

Due to Spina Bifida

Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

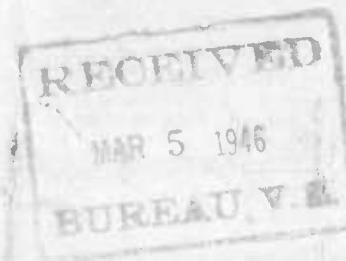
## 23. SIGNATURE

O. Goodson M.D.

M.D. or other

Address 305 Prince St Date signed 3-2-46

Baltimore



Evidence for change of year of birth of deceased is shown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

02900

on

Film No. 101 - March 20, 1946

Reg. Dist. No. 231

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

Prince George's  
County, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 days

Hospital, institution, or street address where death occurred

Prince George's General Hospital

How long in hospital or institution?

2 days

3. (a) FULL NAME

Mrs. Grace Rudeace

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

f

w

6. (b) Name of husband or wife

Mr. Charles S. Rudeace

7. Birth date of deceased (mo., day, yr.)

March 19 - 1884

64 years

8. AGE:

Years  
62

Months

Days

If less than one day

hrs. min.

9. Birthplace

n. y.

(Town, county, and state)

10. Usual occupation

b. u.

11. Industry or business

12. Name

Frank Rudeace

13. Birthplace

n. y.

14. Maiden name

alice Lamont

15. Birthplace

n. y.

16. Informant

charles Rudeace

Address

630 Main St. Laurel MD

17. Burial

cemetery or crematory

Date thereof

(month) (day) (year)

March 19 - 1946

Location

Gak Hill

18. Funeral director

The H C White Co Inc

Address

Laurel 72nd

19. Mar 10

1946

(Date rec'd by registrar)

Amanda Dwyer

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Prince George's

City or town

Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

630

Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

3 - 9

1946 af. 10 18 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 9 1946 to March 9 1946

and that I last saw him alive on March 9 1946

Immediate cause of death

Toxemia +

auto hypostasis

Due to

Diabetes mellitus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John M. Jennings

M. D. or other

Address

Prince George's Hosp.

Date signed 3/9/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1278

02901

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County... Prince George's  
City or town... Cheltenham

(If outside city or town limits, write RURAL and give nearest town)

21 days 12 hrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's Hospital

How long in hospital or institution? 21 days 12 hrs.

## 3. (a) FULL NAME

Mr. Jesse L. Smith

4. Sex

M

5. Color or race

u

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

Sept 4, 1860

8. AGE:

85

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

De Koe, Illinois

(Town, county, and state)

10. Usual occupation.....

Retired Farmer

11. Industry or business

Soaford Smith

12. Name.....

Ohio

13. Birthplace.....

Katherine slate

14. Maiden name.....

Ohio

15. Birthplace.....

Mrs. Howard May

16. Informant.....

8389 Love St. each 14-00

Address.....

Burial.....

Date thereof.....

(Burial, cremation, or removal. Which?)

March 27 194

(month) (day) (year)

Cemetery or crematory.....

Location.....

Cheltenham Maryland

or in Cheltenham

Address.....

Washington D.C. 20201

Name of funeral director.....

Grace J. S. Jones

Address.....

19. Date rec'd by registrar.....

Jesse L. Smith

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

MD.

County.....

P.G.

City or town.....

Cheltenham

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

3-24

19

46

at

2

55

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-2

1946, to

3-24

1946

and that I last saw him alive on

3-23

1946

3-23

1946

Immediate cause of death.....

Choleoptilia int.

Gangrene of gall bladder with peritonitis

Due to.....

Due to.....

Other conditions.....

marked senility

4 years

(Include pregnancy within 3 months of death)

Major findings of operation.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

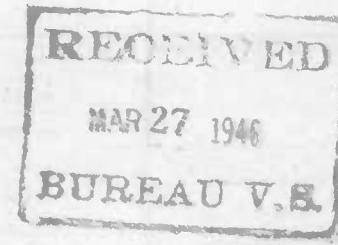
W.B. Morgan M.D.

M.D. or other

Address.....

Mt. Rainier Md.

Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

02902

Reg. Dist. No. 204

## 1. PLACE OF DEATH:

County

City or town 5140 Wheeler Rd SE  
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days) now

Stay in this community (yrs., or mos., or days) 5 yrs.

## 3. (a) FULL NAME

Hugh Mac Snellings

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6 (b) Name of husband or wife

Mary Ellen Snellings

6(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

Feb 23, 1872

8. AGE:

74

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Fredericksburg Va

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Crop Farm

MOTHER FATHER

Walte J Snellings

13. Birthplace

Fredericksburg Va

14. Maiden name

Milred Price

15. Birthplace

Fredericksburg Va

16. Informant

Agnes J Resingers

Address

West. St

17. Burial

Date thereof Mar 4 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Deal Funeral Home.

18. Funeral director

4812 Ga Ave N.W.

Address

March 1 1946 Thomas J Beale

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Prince George

City or town

Crown Hill

Ward No.

Street No.

5140 Wheeler Rd SE

(If outside city or town limits, write RURAL NEAR and give town)

2(a) IF VETERAN, NAME WAR

now

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 1 1946 A.M.P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 28 1946 to Mar 1 1946

and that I last saw him alive on Mar 1 1946

Immediate cause of death

coronary thrombosis

DURATION

Due to

arteriosclerosis

Due to

Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Df operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

now

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

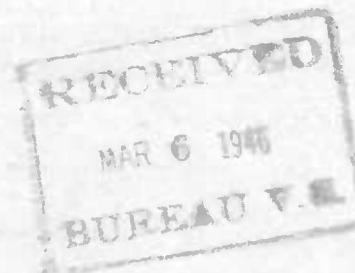
Injured at work?

23. SIGNATURE

Elephantiasis M. D. or other

Address 1225 Tafford H.E. Date signed

Mar 12 1946 Wm (20) D.C.



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VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02904

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 243.

## 1. PLACE OF DEATH:

County..... Prince George's  
 City or town..... (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 mos., 15 days

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 6 mos., 15 days

## 3. (a) FULL NAME

ROBT. A. THOMPSON

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6. (b) Name of husband or wife..... Sara E. Thompson

7. Birth date of deceased (mo., day, yr.)..... October 9, 1900  
 6. (c) If alive, give age..... years

8. AGE: Years	Months	Days	11 less than one day
45	5	9	hrs. min.

9. Birthplace..... Washington, D. C.  
 (Town, county, and state)

10. Usual occupation..... Pressman

## 11. Industry or business

MOTHER FATHER	12. Name..... Arthur Thompson
	13. Birthplace..... Maryland

14. Maiden name..... Elizabeth McCormick

15. Birthplace..... Virginia

16. Informant..... Deceased

Address

17. Burial Date thereof..... Mar 21, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cedar Hill

Location..... Prince George's Co., Md

18. Funeral director..... W. W. Chambers &amp;

Address..... 517 11th St. S.E.

19. March 8, 1946 Rowland S. Phillips  
 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 2130 32nd St. S. E.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 18<sup>th</sup> 1946 at 5<sup>40</sup> A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31<sup>st</sup> 1945 to March 18<sup>th</sup> 1946 and that I last saw him alive on March 18<sup>th</sup> 1946.

Immediate cause of death.....

Pleural and Pneumococcal  
Tuberculosis Complication:  
of lungs and bones of right foot

DURATION..... 13 mo.

Due to.....

Complication:.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

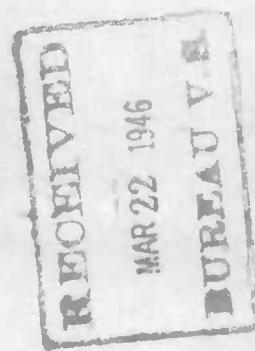
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finucane M.D.

M. D. or other

Address..... Glenn Dale, Md. Date signed..... 3/18/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1703

## CERTIFICATE OF DEATH

Reg. Dist. No.

02905  
245

## 1. PLACE OF DEATH:

County.....

Person.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Belmont Memorial Hospital

How long in hospital or institution?.....

2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Person..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

5812 Pontiac

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Clarence Edward Troft

## 3. (b) Social Security Number

4. Sex

Male | white | married

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

Virginia G. Troft

7. Birth date of deceased (mo., day, yr.)

June 10, 1888

8. (c) If alive, give age.....

years

8. AGE:

Years      Months      Days      If less than one day

57

8

22

hrs.

min.

9. Birthplace.....

Uniontown Pa

(Town, county, and state)

10. Usual occupation.....

Contractor

11. Industry or business.....

Building

FATHER

12. Name.....

Robert T. Troft

13. Birthplace.....

Penn.

14. Maiden name.....

Anna Marks

15. Birthplace.....

Penn.

16. Informant.....

Jeanne Green

Address

5403 Edmonston Rd East Baltimore

17. Burial

Date thereof.....

3-5-46

(month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory.....

Mt. Hebron Cemetery

Location.....

Wash. D.C.

18. Funeral director.....

Lowchance C

Address

Benedict and

March

(Date rec'd by registrar)

19. James Sevey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 2 1946 at 3:0A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....

19.....

and that I last saw him.....alive on.....

19.....

Immediate cause of death.....

Hemorrhage  
and shock

Due to.....Crushed Chest

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of 3-2-46

Where did injury occur?.....

(City or town) P.O. Rd

(County) Route #

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injury to self w

Pedestrian struck by car.....

Injury to others

Replayed a decap' Hammer.....

Injury to self

23. SIGNATURE.....

M. D. or other

Address.....

Date signed 3-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR. 5 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-1

02906

243

Reg. Diat. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Prince George's  
 City or town..... (rural) Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 8 yrs., 6 mos., 10 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 8 yrs., 6 mos., 10 days

## 3. (a) FULL NAME

TURNER, RUSSELL

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... April 24, 1918

8. AGE: Years	Months	Days	If less than one day
27	10	27	hrs. min.

9. Birthplace..... Washington, D. C.  
(Town, county, and state)

10. Usual occupation..... Painter

## 11. Industry or business

12. Name..... Frederick Turner

13. Birthplace..... Virginia

14. Maiden name..... Mary Montague

15. Birthplace..... Virginia

16. Informant..... Decedent

## Address

17. Removal..... Mar. 24, 1946  
(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

## Cemetery or crematory

Location..... to Washington, D.C.  
John T. Phillips

## 18. Funeral director

Address..... 501 3rd St. S.W.  
Date rec'd by registrar.....19. Mar. 23, 1946 Rowland & Phillips  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 1217- First St. S. E.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 23, 1946, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Sep. 13, 1937, to March 23, 1946,  
and that I last saw him alive on March 23, 1946.

## Immediate cause of death

Pulmonary Tuberculosis

DURATION

81/2 yrs.

Due to.....

Due to.....

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

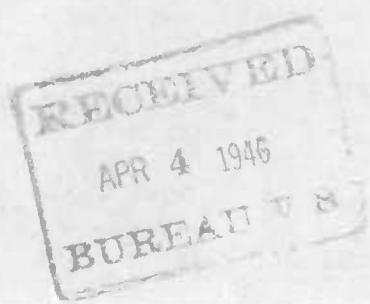
## Means of injury

Injured at work?

## 23. SIGNATURE..... Daniel Leo Finegan MD.

M. D. or other

Address..... Glenn Dale, Md. Date signed..... 3/23/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-2)

02907

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH  
County: *Ore Geo Co*

City or town: *Hyattsville Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *3 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*N. Snowden Valk*4. Sex *Male* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *married.*6.(b) Name of husband or wife *Roberta Valk.*7. Birth date of deceased (mo., day, yr.) *Sept 9, 1860.*6.(c) If alive, give age *71* years8. AGE: Years *85* Months *1* Days *1* If less than one dayhrs.  min. 9. Birthplace *Virginia*  
(Town, county, and state)10. Usual occupation *salesman :-*11. Industry or business *white & co Jewelry co. N.Y.*12. Name *Jacob Valk.*13. Birthplace *England*14. Maiden name *Ann Massie :-*15. Birthplace *England :-*16. Informant *Mrs Roberta J Hardwick*Address *5210 - 42 place Hyattsville Md*17. Burial Date thereof *March 4, 1946*  
(Burial, cremation, or removal. Which?)Cemetery or crematory *Fort Lincoln*Location *Colmar Manor Md*18. Funeral director *F. Gascia son*Address *Hyattsville Md.*19. *Mars H. 1946 James Avery.*  
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *Md* County: *Ore Geo Co*City or town: *Hyattsville Md*

(If outside city or town limits, write RURAL and give nearest town)

Street No.: *5210 - 42 Place*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *3 - 1 1946 at 7 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec 1945 Mar 1 1946*and that I last saw h. m. alive on *3-1-46* 19...

Immediate cause of death

*myocarditis* DURATION *1 yr**Bunhs pneumonia* *4 yrs*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

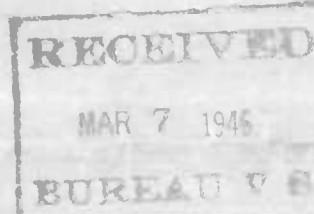
Means of injury Injured at work?

23. SIGNATURE *Leonard Hays*

M. D. or other

Address *Hyattsville Md.* Date signed *3-1-46*

Holland



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B2

## CERTIFICATE OF DEATH

02908231  
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-1

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Dead on arrival

Hospital, institution, or street address where death occurred:

Prince George General Hospital

How long in hospital or institution?.....

## 3. (a) FULL NAME

William Thomas Van Pelt

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Oct 18, 1945

6. (c) If alive, give age..... years

8. AGE:

Years      Months      Days

4

26

If less than one day

hrs.

min.

9. Birthplace.....

Washington DC

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

Robert E. Van Pelt

12. Name

Maryland

13. Birthplace

Catherine Person

14. Maiden name

Richmond, Va

15. Birthplace

Robert E. Van Pelt

16. Informant

Burial

Date thereof (month) (day) (year)

17. Cemetery or crematory

Fort Lincoln Cemetery

Location

Washington D.C.

18. Funeral director

Flesch's Sons

Address

Hyattsville Md.

19. (Date reg'd by registrar)

3/16 1946 Amanda Dauney

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Ardmore (If outside city or town limits, write RURAL and give nearest town)

Street No.....

1 First Street (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 14 1946 at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death.....

asphyxia

DURATION

Due to..... smothered in bed clothing

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident Date of 3-14-46

Accident, suicide, or homicide.....

Where did injury occur? Ardmore P. O. Box

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury smothered in bed clothing

Include work

Repeat medical history

Surgery

M. D. or other

Signature John J. Ford

Address Forest Hill Reg. date signed 3-14-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

02909  
245

Reg. Dist. No.

1. PLACE OF DEATH: Prince Georges County  
 County: Riverdale Md.  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day - 5 hrs. 15 min  
 Hospital, institution, or street address where death occurred: Elmhurst Memorial Hospital  
 How long in hospital or institution? 1 day - 5 hrs - 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: Washington D.C.  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: 1340 - Newton St N.W.  
 (If rural, give LOCATION)

## 3. (a) FULL NAME

Bertha Ellen Walker

4. Sex: Female 5. Color or race: W. 6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Lee Moore Walker

6. (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): May 31 1893

8. AGE: Years: 52 Months: 9 1/2 Days: 75 If less than one day: hrs: min:

9. Birthplace: Deer Park, Garrett Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Walter Scott Company

12. Name: Walter Scott Company

13. Birthplace: St. Louis, Mo.

14. Maiden name: Frances Rebecca Moreland

15. Birthplace: Sommug W. Virginia

16. Informant: Mary Elizabeth Hartman (Sister)

Address: 4635 Silver Hill Rd. S.E. D.C.

17. Removal: Date thereof: March 16 1946  
 (Burial, cremation, or removal. Which?)

Cemetery or crematory: Washington D.C.

Location: The S. H. Jones Co.

18. Funeral director: The S. H. Jones Co.

Address: 2901 14th St. N.W.

Phone: 16 Date rec'd by registrar: 1946 Jerry Serry

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-15-46 19 al 11 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 14 1946 to Mar 15 1946 and that I last saw her alive on Mar 15 1946

Immediate cause of death: cerebral accident

Duration: 2 days

Due to: arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death):

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

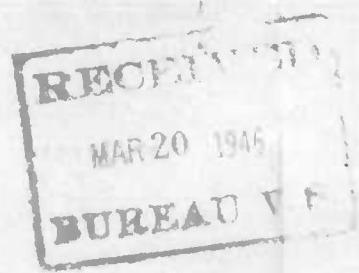
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Sam G. Fadley M.D. or other:

Address: 1201 16th Date signed: Apr 16 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of age of deceased is shown on

FILM No. 101 APR 2 - 1946

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2d

## CERTIFICATE OF DEATH

02910

231

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Prince Georges.

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

John Edward Walker

### 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widower

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

April 20<sup>th</sup> 1876

8. AGE: Years

Months

Days

If less than one day

69 . . . . . hrs. . . . . min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Carpenter

11. Industry or business

12. Name..... Cynthia E. Walker

13. Birthplace..... England

14. Maiden name..... Alver Wilson

15. Birthplace..... England

16. Informant.....

Miss Frank Green

Address

1416-Est. N.E. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof..... March 6 1946

Cemetery or crematory.....

Arlington Nat'l Cemetery

Location.....

Arlington, Va.

18. Funeral director.....

W. W. Chambers Lee

Address

Riverdale Md.

19. Date rec'd by registrar

3/3

1946

Annada Daunes

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD.

County Prince Georges.

City or town Columbia Park (Landover Hills)

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... Spanish-American

### MEDICAL CERTIFICATION

2D. DATE OF DEATH

3.2

1946 at 11A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3.1 1946 to 3-2 1946

and that I last saw him alive on 3-1 1946

Immediate cause of death

myocarditis

DURATION

2 hr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

Glenayn Hayes

M. D. or other

Date signed 3.2.46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02911

## CERTIFICATE OF DEATH

Reg. Dist. No. 142

## 1. PLACE OF DEATH:

County..... Prince George Co.  
City or town..... Silverside, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

## 3. (a) FULL NAME

Warrick, Catherine

4. Sex F 5. Color or race Negro 6. (a) Single, married, widowed, or divorced widow

Alfred Warrick

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

50 hrs. min.

9. Birthplace..... Prince Geo County

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Richard Scott

13. Birthplace..... Maryland

14. Maiden name..... Ann Humphrey

15. Birthplace..... Maryland

16. Informant..... Olena Bailey

Address..... 423-Butternut St. Md.

17. (Burial, cremation, or removal. Which?) Cemetery or crematory

Date thereof..... 3-13-46 (month) (day) (year)

Cemetery or crematory..... Chapek Hill - Md.

Location..... Chapek Hill - Maryland

18. Funeral director..... J. Rhiney &amp; Co.

Address..... 901-3 St. S.W.

19. Date rec'd by registrar..... 3-10-46

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George

City or town..... Silverside (If outside city or town limits, write RURAL and give nearest town)

Street No. 1860 Lexington Rd. Jr.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 10 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1932 to March 10 1946

and that I last saw her alive on March 9 1946

Immediate cause of death..... Myocarditis

Secondary cause..... Ischaemic

Due to..... Influenza (Virus)

Due to..... arterosclerosis (artery) year

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

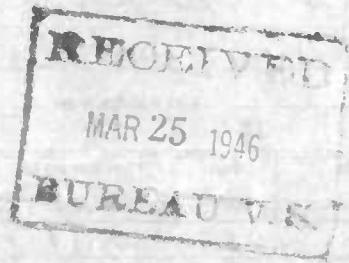
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... E. W. Schwartz, M.D.

M. D. or other

Address..... 1225 Talbot St. W. Date signed..... Mar 10, 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 158

## CERTIFICATE OF DEATH

03124  
232

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

P. G. Co.  
Upper Marlboro Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 mos 22 days

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution?.....

## 3. (a) FULL NAME

Baby Hedges

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

female colored

single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Nov. 26 1945

8. AGE: Years

Months

Days

If less than one day

3 22 hrs. min.

9. Birthplace.....

Upper Marlboro Md.

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business.....

none

12. Name.....

Bessie Hedges

13. Birthplace.....

Md.

14. Maiden name.....

Laura Pinkney

15. Birthplace.....

Md.

16. Informant.....

Laura Hedges

Address

Upper Marlboro Md.

17. Burial

Methodist

(Burial, cremation, or removal. Which?)

Date of prep. (month) (day) (year)  
1946

Cemetery or crematory.....

Location.....

Upper Marlboro Md.

18. Funeral director.....

Fitchie Brothers

Address

Upper Marlboro Md.

19. Death rec'd by registrar.....

Date rec'd by registrar  
March 18 1946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

P. G. Co.

City or town.....

Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 18 1946 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that deceased from

March 12 1946 to March 18 1946  
and that I last saw her alive on March 17 1946

Immediate cause of death.....

malnutrition

Due to irregular and improper diets

Due to.....

none sugar

Due to.....

none

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

Z M Brady M.D.

M.D. or other

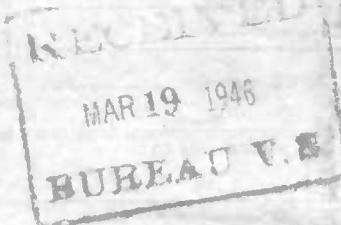
Address.....

Sept Pleasant Rd.

Date signed.....

3/18/46

Believe this child was born in  
Washington, D.C. Father in 1941 was.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11291243  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Prince George's

City or town (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 2 mos., 12 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 2 mos., 12 days

## 3. (a) FULL NAME

LUCINDA R. WILLIAMS

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored Married (separated)

6. (b) Name of husband or wife Reginald Williams

7. Birth date of deceased (mo., day, yr.) January 14, 1912

8. AGE: Years Months Days If less than one day  
34 2 1 hrs. min.9. Birthplace Waynesboro, S. Carolina  
(Town, county, and state)

10. Usual occupation Govt. Clerk

## 11. Industry or business

12. Name Orin Russell

13. Birthplace Waynesboro, S. Carolina

14. Maiden name Lucy Harrison

15. Birthplace Waynesboro, S. Carolina

18. Informant Decedent

## Address

11. Removal Date thereof Mar. 16 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

## Cemetery or crematory

Location to Washington D.C.

## 18. Funeral director

Address 901-3rd St. S.W.

19. 3/16/1946 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C.

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 815 Delaware Ave., S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15<sup>th</sup> 1946 at 8<sup>06</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 31<sup>st</sup> 1944 to March 15<sup>th</sup> 1946  
and that I last saw her alive on March 15<sup>th</sup> 1946

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

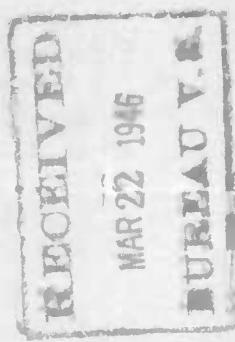
Means of Injury

Injured at work?

23. SIGNATURE Daniel Leo Pinicarre M.D.

M. D. or other

Address Glenn Dale, Md. Date signed 3/15/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

LX5

1. PLACE OF DEATH: Blessing Georges  
Cathedral, Md  
 County \_\_\_\_\_  
 City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? \_\_\_\_\_  
 Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

3. (a) FULL NAME Judith Allen Wright  
 4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) July 18, 1944 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 1 Months 7 Days 5 If less than one day hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Baltimore, Md  
(Town, county, and state)

10. Usual occupation: \_\_\_\_\_

11. Industry or business Willingard Wright

MOTHER FATHER  
 12. Name Willingard Wright  
 13. Birthplace Baldo, Md

MOTHER FATHER  
 14. Maiden name Elgreen Deal  
 15. Birthplace Baltimore, Md

16. Informant Marine Home records  
 Address Cathedral, Md

17. BURIAL Date thereof 9-14-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer  
 Location BALTIMORE

18. Funeral director MARY M. WIEDEFFELD  
 Address 502 E. 22nd ST.

19. Date rec'd by registrar 3/15 19. Date 46 A.W. Hedrich  
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MD County \_\_\_\_\_

City or town BALTIMORE  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2201 C.H.R.I.S.T.O.P.H.E.R. A.V.E.  
(If rural, give LOCATION)

2.(a) If veteran, name war: \_\_\_\_\_

3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 1946 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Mar 12 1946 and that I last saw her alive on Mar 1 1946.

Immediate cause of death: \_\_\_\_\_

Causes contributing to death: Congenital heart birth

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions Mongolian Idiots birth

(Include pregnancy within 8 months of death)

Major findings or operations: \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John J. Maloney MD N. D. or other \_\_\_\_\_

Address Hyattsville, Md Date signed 3-12-46